Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2007 11:05 AM October 0 7, Joseph Sachs /Medical 4c County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis
If Under 1 Year | If Under 24 Hrs. Anne Arundel Anne Arundel Medical Center 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Feb 26, 1934 216-30-6643 Director 73 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural" ~ " any injury or other traumatic every ". 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√ No Director MD Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1417 Catlyn Place 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No Specify. Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Anne Arundel Govt city planner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose LaPides Bernard Sachs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1417 Catlyn Place Annapolis, MD 21401 Jacqueline Sachs/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/10/07 Washington, D C Howard Univ Med School 4x Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service License 3821 14th Street N W Washington, D C 20011 Terry A Austin Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical equence of): Due to (or as a cong Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) signed by the a 1 Yes 2 No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 3 Probably 4 Unknown 2 No Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s autopsy performe this certificate 2 No 1∐ Yes Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ Mo Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဥ funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: To the Funeral Director: After completely filled in by the funera (Month, Day Year) or Attending 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide To the Hospital o within 24 hours aff To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 30. Name a ed cause of teath (Item 23a) (Type, Print 20/100

Registrar

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

Year)

2007

Registrar's Signature

P.O. Box 68760, or Vital Records,

72 hours after death with the Maryland

requires that the death certificate be executed physician Physician: or Attending After death within 24 hours after death

To the Funeral Director:

Certification: To

Medical 5 pur DB nos

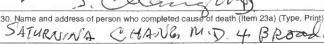
SATURATINA 31. Date filed (Month, Day, Year) State Registrar

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier



BROWLWay

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Frostoury Maryland 21532

32. Resistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Yea 07 Ethe1 10 0938 Shives Mary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS Braddock Campus Cumberland Allegany If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 91 Director 218-30-0042 06/12/1916 Marvland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Director MD 1 ☐ Yes 2 📉 No Garrett Grantsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the M∗dir. ■ Examiner must be r 254 Shawnee Lane 21536 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>Ş</u> 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental h Be Yommer Stanton Henry Alice ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 is 137 Shawnee Lane, Grantsville, MD 21536 Robert W. Shives / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If iter any Injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland Crematory 10/18/2007 4 ☐ Donation 5 ☐ Other (Specify) Cumberland. MD 21. Signature of Funeral 9 ervice Licenses 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Candlovuscular Atherosclorotic 2 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duc to (or as a consequence of): Examiner signed by the attending physician and the detached for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 Other (specify) 1 ☐ Yes 2 🔀 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> apritic 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an has autopsy this certificate 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA ို 1 Nnpatient funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number workshin) 00055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frostburg MD21532 WONSOUK 48 Turn Terrace SHIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 18 Registrar 2007

DHMH 17 Rev 1/2001

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ctober 15,2007 Ruby Naomi Scritchfield /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland Lions Manor Nursing Home If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🗷 F 85 1-26-1922 Director 214-62-4005 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 1 □Yes 2 No Director Hundman Bedford PA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 15545 Be Completed by Funeral 2812 Hundman Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. Pages 1 and 2 should be filed within 72 hours afternent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carrie Eudora McGregor George M. Oster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2735 Hyndman Rd., Hyndma, PA 15545 G. Edward Scritchfield Saltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 MRemoval from State 10-19-07 Hyndman PA 4 ☐ Donation 5 ☐ Other (Specify) Porter Cemeteru 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harvey H. Zeigler Funeral Home 169 Clarence St. Hyndman PA 15545 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SUDDEN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is listed as each Due to (or as a sunsequence of). Examine The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No Ö 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No page 2 s death? certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) tober 16,2007 5 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Frint)

Registrar
DHMH 17 Rev 1/2001

nas

State

Khanna, MD

OCT 1 9 2007

31. Date filed (Month, Day, Year)

1221 National

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08043 State of Maryland / Department of Health and Mental Hygiene Brian Heath Schafer 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 15, 2007 0717 hrs **Medical Examiner** Brian Schafer Heath 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Calvert Prince Frederick Calvert Memorial Hospital 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In vrs. last birthday) **Funeral** Foreign Country) Months Davs Hours Min Director 215-04-7262 1 X M 2 F 1968 39 MD Mav Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Yes 2 X No 23a or 28a-f show Calvert Owings Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9100 Sam Owings Place United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces Never Married 2 X Married Yes 1 Yes 2 X No specify: 3 Widowed Divorced If Yes, Give Yeer Specify: white 5 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) If item 27 is marked other than event, the Medical Baltimore, MD 21215-0036 Pages 1 and 2 should be filed within tent of Health and Mental Hygiene. 12 Master Carpenter Construction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ginger Leslie Beans Schafer Suzanne Pickeral 19a, Informant's Name/Relationship (Type, Print) (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Ann Cook Schafer, 9100 Sam Owings Place, Owings, MD 20736 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Burial 2 X Cremation 3 Removal from State ortant: Metropolitan Crematory 10-19-07 Alexandria, VA Donation 5 Other Specify 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service License 8325 Mount H<u>armony Lane, Owings,</u> MD 20736 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Narcotic intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - tran Physician/Medical X UNPENDED #52,27,28a-f, perME, g872, 10/29/2007 TI The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate 2 No ✓ Yes 2 No 1 🗸 Yes 26 Place of Death (Check only one 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: ER/Outpatient 3 V DOA Nursing Home 5 Residence 6 Inpatient 2 1 🗸 Yes 2 No After 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Pending Yes 2 x No unk To the Funeral Director: Fnd 10/15/2007 Fnd 6:25 am 2 Investigation Accident filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be 3624 10th St. North Beach. MD determined (Specify) single family residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 16, 2007

32. Registrar's Signature

and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

2007

3 2

29b. Signature and title of certifier

Carol Allan, MD 31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2:00 P M Oct 10, 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 45737 Oregon Way Lexington Park St. Mary's 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1 □ M 2 □ F Director 215-36-5047 68 MD Jul 28, 1939 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3011 Hunting Creek Road 20639 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ (No Specify Specify: Black 3 □ Vidowed 4 □ Divorced Year or Dates: "natural". the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 9 alth and Mental Hyc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should b Gladvs Elizabeth Brooks George Edward Smith ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45737 Oregon Way Lexington Park, MD 20653 Towanda Estep /Daughter Department of Health Important: If item 27 any Injury or other to Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10/15/07 Huntingtown, MD Young's Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sewell Funeral Home Blodes 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician VOSJOCTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examine Sequentially list conditions Due to for as a consequence of : Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician sthe burial Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.O. ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ģ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificate 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 6 Dother (Specify) Daugh Ris Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred Injury at Work? After Medical Certification: Division or Attending 5 Pending investigation 1 🔼 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident neral Director: , filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Funeral Dire To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0055751

dew 2

State Registrar 30. Name and address

31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

OBOX 1507 Leonard fown MD

erson who completed cause of death (Item 23a) (Type, Print)

nmid

2007

32. Registrad

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 12, **Physician** 2007 4:00 A M J RACHAEL SHAW /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🕱 F 77 Vrs 578-38-2430 Nov. 7, 1929 Director N. Carolina Usual Residence of Decedent 10c. City, Town or Location show 10a, State 10b. County 10d. Inside City Limits an "natural", or items 23a or 28a-f shov Medical Examiner must be notifled at 1X Yes 2 No Maryland Montgomery Director Rockville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 199 Rollins Avenue - Apt. 636 20852 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. <u></u> Specify: White 3 Widowed 4 Noivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. traumatic event, the Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked ofthe any lighty or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be 2 Artis Curry Flossie Crotts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28811 Kemptown Road, Damascus, Maryland John Dennis Shaw - son 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematorium 10/13/07 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 21. Signature of Funeral Servicers Kozert 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Throat GANCIN **Physician** MONTHS /Medical Due to (or as a consequence of). Examiner bhasia MONTHS Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ov as burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Dixbetes McChitus No 3 Probably 4 Unknown Tobacco 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and to 29d. Date signed (Month, Day, Year) 10/12/07 00062223

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month.)

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRAY CENT BOLANUM, MO 196 TT DRIVE, FREDERICE, MD 2/702

Registrar's Signature

			State Registrar		rtificate of Death	R	eg. No.	34508
	Physicia		1. Decedent's Name (First, Middle, Last)  Raymond	Smith		2. Date of Dear Month	th Day Year 10, 2007	3. Time of Death 6:40 A M
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number) 49270 Curley's Road		4b. City, Town, or Location of Dea Ridge		4c. County of Dea	
	Funeral Director			rs. last birthday) Yrs.	If Under 1 Year		9. Bir (Year) Co	thplace (State or Foreign ountry) MD
	Maryland a-f show ifled at	ctor	Usual Residence of Decedent           10a. State         10b. County         10c. 0           MD         Saint Marys	City, Town or Lo	cation Ridge			10d. Inside City Limits 1 □Yes 2X No
	3a or 28	al Dire	10e. Street and Number 49270 Curley's Road		10f. Zip Code 20680	1	0g. Citizen of What Co U.S.	-
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 ☒ Yes 2 □ No If Yes, Give Year or Dates:	1	Uwas Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 INo Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whi Specify: Bla	te, etc.
Maryland 21215-0036	within 72 ho ene. than "natur he Medical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) 12	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) Transporter	orking	16b. Kind of Business Federal Go	·
nd 2	be filed ntal Hygi id other event, t	Be	17. Father's Name (First, Middle, Last)  Richard Smith		18. Mother's Na	me (First, Middle, i	Maiden Surname) Va Corsey	
Maryla	nd 2 should Ith and Mer 27 is marke traumatic	2	19a. Informant's Name/Relationship (Type. Print) Elmira Davis /Niece	1	ng Address (Street and Number or F 2 Piscataway Road Clinto	lural Route Numbe	r, City or Town, State,	Zip Code)
Baltimore,	Pages 1 ar nent of Hea ant: If item 2 ary or other		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)		sition (Name of matory or other place)  JMC Cemetery 10	Date 0/16/07	20c. Location - City or	
Balt	permit. Departr Importa any Inji		21. Signature of Funeral Service Licensee  **Description**  **Alloward A. Serwell  **The Service Licensee**  **The Service	22	2. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach R		rederick MD 20	9678
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on exhibite.  Immediate Cause (Final disease or condition resulting in death)  a	ath. Do not ent		ac or respiratory arr	rest,	Approximate Interval Between Onset and Death
68760,	ifficate be executed g physician and as the burial-transit	al Examiner	Gequaritiany fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consider of the condition of the condi	equence of):	ANC VIE WALL	cence		
.O. Box	The law requires that the death certificate ate has been signed by the attending phy bage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf preg. 1 □ Live birth 2 □ Fe	etal death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>		23d. Date of de Month	elivery Day Year
rds, P	quires that en signed b uld be deta	þ	Part II. Other significant conditions contributing to death but not re	esulting in the u	nderlying cause given in Part I.		bacco use contribute t es 2 □ No 3 □ F	o the cause of death? Probably 4 10 Unknown
Vital Records, P.	: The law requir cate has been si page 2 should I	Completed				24a. Was a autop perfor	sy prior to med? death?	
Division or Vita	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1  Accident  5  Pending investigation  28a. Date of Injury (Month, Day Year)	28b. Time of	nt 3 DOA Other: 4 Nursing	<del></del>	ne) lence 6 □Other (Spi ow injury occurred	ecify)
Divisi	al or Atter s after deal al Director ed in by the	Certification:	3   Suicide   6   Could not be determined   28e. Place of injury - At building, etc. (Spe	home, farm, str		28f. Location (S City or Tow	treet and Number or F rn, State)	Rural Route Number,
	e Hospital 24 hours a e Funeral letely filled	Medical (	29a. Certifier (Check only one) Certifying Physician: To the best of my k	nowledge, death ination and/or in	h occurred at the time, date and pla evestigation, in my opinion, death oc	ce, and due to the courred at the time, or	cause(s) and manner a date and place, and du	is stated. le to the cause(s)
•	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mor	
) )	Λα.		30. Name and address of perso, who completed ause of death (II	<b>17</b> ) tem 23a) (Type,	D/4285		10-11-0	5/
Ā	Sta	te	William Boyd, M.D. 25365 Point Lookout I  31. Date filed (Month, Day, Year)  32. Registrate Sig	gnature				
	Registr	ar	OCT 1 5 2007 ►	···· K	Argell 8			

		-	For	icasc	Type or State o		land / [	Эера	artmen	t of H	lealth	and M	lental H	ygier	ne C	oie.	0.1	- 0 0
			= State Registrar					Cei	rtificat	e or i	Deatr	1	001 15	Reg. N	10.2	U	34	509
Phys /Me	sicia edica	n	1. Decedent's Name (First,  Esther B		<sub>st)</sub> kinner								2. Date of E Month Octob		Day 200	Year 7	3. Time of 4:10	
Exa			4a. Facility Name (If not ins	_		mber)						of Death			c. County			
· · <sub>3</sub> ,			7307 Sherif			7 1 //-	a um lant his	eth alo. ()		indov	er I If Unde	r 2/1 Hrs	8. Date of E		Princ		orge's	
Funei Direct			5. Social Security Number 578-56-7277		M 2⊠F	68	ı yrs. last bir	Yrs.	Months	Days	Hours	Min.	Dec 1	Day, Yea	38	Cou	olace (State ontry) ingtor	_
and			Usual Residence of Deceder 10a. State 10b. C			10	c. City, Town	n or Lo	ocation							1	10d. Inside C	ity Limits
72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	3	ctor	MD Pri	nce G	eorge's		Land	ove	r									2 □ No
a or 28		Funeral Director	10e. Street and Number 7307 Sherif	f Dog	a				10f. Zip	)785				10g. (	Citizen of V	Vhat Cou	ntry?	
ns 23		era	11. Marital Status	ı koa	12. Was Dece	edent Ever	r in U.S.	13.			ispanic O	rigin? (Sp	ecify Yes or I			e - Ameri	can Indian,	
pomeration of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at		by Fun	1 ☐ Never Married      3 ☐ Widowed 4 ☐ Div		Armed Fo 1 ☐ Yes If Yes, Giv Year or D	rces? 2 <b>X</b> No ve			If Yes, spe 1 ☐ Yes		Specify		ecify Yes or I Rican, etc.)		Specify Specify	ck, White, $B1$	etc. ack	
"natura edical E		Completed	(Specify only		ade completed)		16a.	Deced	dent's Usu kind of wo DO NOT u	al Occup ork done o	ation during mo	est of work	ing	16b.	Kind of Bu	usiness/In	dustry	
iene. than		dwo	Elementary/Secondary (0	)-12)	College (	1-4or 5+)				atch				P	rivat	:e		
Hyg other		BeC	17. Father's Name (First, N	liddle, Last								ner's Nam	e (First, Midd	lle, Maid	en Surnam	ne)		
lenta ked		9 2	Bernard	Barn	ett					1	An	nie	Harpe	r				
Ith and N 27 is mai			19a. Informant's Name/Re Samuel Skin			and							al Route Nun					
f Hea		1	20a. Method of Disposition			2	20b. Place of cemete.	f Dispo	osition (Na	me of	20)		Date	20c.	Location -	City or T	own, State	
ent o	5		1 XBurial 2 ☐ Crem 4 ☐ Donation 5 ☐ Of			State	Harmo					10-1	2-2007	I	andov	er,M	larylar	nd
oartm Sortar	ej l	1	21. Signature of Funeral S		-	1	,	-		-	ss of Faci		B. Je				-	
a m	, a	1	rivau	UM	ogler	all		-	7474	Land	lover	Roa	d Land	over	, Mar	ylan	d 2078	35
nysicia Medic			23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	se, or com	one cause on e	each line.	e death. Do	te	ter the mod		_		or respiratory	arrest,			Approxima Interval Be Onset and	te tween Death
xamin		_	Sequentially list conditions		b	Fee	on équence	les	ree	1						- 1		
executed in and ial-transit		Examine	Sequentially list conditions if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	1	c Due to	(or as a cc	on equence	oi).										
e attending physician and d for use as the burial-transit	5	_	resulting in death) Last	l	Due to	(or as a co	onsequence	of):										
ing phy e as the		Medic	IF FEMALE:							-								
y the attending		Physician/Medica	23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			birth 2 🗀 nant at tim	oregnancy Fetal death ne of death		⊒Ectopic p ⊒ Other (s <sub>i</sub>		У			-		te of deliventh	-	Year
been signed by the a	3	<u>م</u>	Part II. Other significant c	onditions	contributing to d	eath but n	ot resulting in	n the u	inderlying (	cause giv	en in Par	t I.			-		the cause of bably 4	
has le 2		Completed		-									24a. Wa au pe 1□ Yes	topsy rformed	?	Were autoprior to condeath?  1 ☐ Yes	opsy findings ompletion of a	available cause of
		Φ	25. Was case referred to n	nedical							26. Pla	ce of Deat	th (Check onl		110			
g: ig	5	To B	examiner? 1 Yes 2 No		Hospital: 1	Inpatient	2 🗆 ER/Ou	utpatier	nt 3 D	OA Oth	ier: 4 □ t	Nursing Ho	ome 5. ŽRe	esidence	6 □Oth	er (Speci	ify)	-
After th funeral			27. Manner of Death 1 ☑ Natural 5 ☐	Pending	28a. Date (Mon	of Injury oth, Day Ye		Time o Injury	of	28c. Injur Wor	y at k?		28d. Describ	e how is	ijury occur	red		
		atic	2 Accident	nvestigatio	n	, ,	,		М		Yes 2[	□No						
Direct d in by t		Certification:	3 ☐ Suicide 6 ☐ 6 4 ☐ Homicide	Could not be determined	200. Flace	of injury - ling, etc. (8	- At home, fa Specify)	arm, sti	reet, factor	y, office			28f. Location City or 1	n (Street Town, St		er or Rui	al Route Nui	mber,
To the Funeral Director: completely filled in by the		edical			hysician: To the miner: On the b and man		amination ar		nvestigation	n, in my o	opinion, d	eath occu						(s)
To t		Σ	29b. Signature and title of	certifier	Ha	n	w	M			e number		306				, Day, Year)	
40			30. Name and address of p	Hai	rris,	MO	900	(Туре,	Print) PST	99t	te R	1	306 ste 3	00	Anna	epole	18 1	1901
	Sta istra		31. Date filed (Month, Day, OCT 1 2 2007	Year)	32. F	negistrar's	Signature											

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at	
	Physicia /Medica Examine	
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

Funeral Director

_1	For State Registrar		State of	Marylan		artment of F rtificate of		nd Menta	l Hygien Reg. N		7 31.51
n il	Decedent's Name		Last) Marie Bari	nes Sau	nders			Mor	e of Death oth D cober 7	2007 7, 2007	
		mas Mor	give street and num e Nursing n Center	and		4b. City, Town, o	r Location of I		4	County of E	Georges
	5. Social Security No. 577–52–98	861	6. Sex 1 □ M 2 <b>X</b> F	7. Age ( <i>In yrs. I</i>	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Mo.	e of Birth nth, Day, Yea <b>ust 22</b>	1027	Birthplace (State or Fore Country) Maryland
I ⊢	Usual Residence of 10a. State	10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Lin
jo	Maryland	Prince	e Georges		Hyat	tsville					1 X Yes 2 □
Director	10e. Street and Nur	nber				10f. Zip Code			10g. (	Citizen of Wha	t Country?
	4922 I	LaSalle				2078				nited S	
by Fur	11. Marital Status 1		Armed For	2 <b>X</b> No e		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	Specify:	n? (Specify Ye: Puèrto Rican, e		Black, V	American Indian, White, etc. Black
ete	(Spec	15. Decedent's ify only highest	s Education grade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	oation during most o	of working	1	Kind of Busine	•
Completed	Elementary/Second 12th gra		College (1-	-4or 5+)		etary	<i>u)</i>			Labor	partment
	17. Father's Name (		ast)				18. Mother's	s Name (First,			
To Be	James	Andre	w Barnes				Mar	y Oliv	ia Wo	odland	
	19a. Informant's Na	ame/Relationshi	ip (Type. Print)		19b. Maili	ng Address (Street	and Number	or Rural Route	Number, City	y or Town, Sta	te, Zip Code)
	Carlton	Willian	n Saunder:	s (Son)	6906	Lyle St	reet;	Lanham,	Mary1	and 20	706_
	20a. Method of Disp 1	☐ Cremation	3 □Removal from 9	State	emetery, cre	osition (Name of matory or other place)  od Cemete:	i	Date ct.15,2			y or Town, State  ton, D.C.
	21 Signature of Ru	ineral Service L	digensee	July		2. Name and Addre R. N. Hor 600 Kenne	ton Co				inc. on,D.C. 2001
	23a. Part1. Enter the shock, or heat Immediate Cause (disease or condition	rt failure. List o Final	complications that cannot one cause on ea	ach line.	n. Do not en		ng, such as ca	ardiac or respir	atory arrest,	.,	Approximate Interval Betweer Onset and Deatl
r e	resulting in death)  Sequentially list coif any, leading to im		Due to (	or as a consequ	uence of):			210000			years
edical Examine	Cause (Disease or that initiated events resulting in death) L	injury	c	or as a consequ	uence of):						
Physician/M	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 22 9 ☐ Unknown	months?		irth 2 Feta ant at time of d	Ideath 3	□Ectopic pregnanc □ Other (specify)	у			23d. Date o Month	f delivery Day Year
by Pi	Part II. Other signif	ficant condition	ns contributing to de	eath but not resu	ulting in the u	ınderlying cause giv	en in Part I.	23	e. Did tobacc	o use contribu	te to the cause of death
ed t	End Stag	ge Renal	L_Disease	; Demen	tia;				1 ☐ Yes	2 No 3	☐ Probably 4 X Unkn
Completed			Cerebral : tus; Perij			ar Dicec		-	a. Was an autopsy performed	prio dea	re autopsy findings avail r to completion of cause th? Yes 2 \( \sumbole \) No
a l	25. Was case refer examiner?		Lus, Terr	pherar	Vascui	ar visca:		of Death (Chec			103 2 10
To B	1 □ Yes 2 📉		Hospital: 1 🗆 li	npatient 2	ER/Outpatie	nt 3□ DOA Oth	ner: 4 🛮 Nurs	ing Home 5	Residence	6 □Other (	(Specify)
ation:	27. Manner of Deat  1 X Natural  2 ☐ Accident  3 ☐ Suicide	h 5 ☐ Pending investiga 6 ☐ Could no	ation	th, Day Year)	28b. Time of Injury	M 1□	ry at	28d. De	scribe how in	jury occurred	
Certifi	4 ☐ Homicide	determin	ned 26e. Place buildii	ng, etc. (Specif	y) 	reet, factory, office		City	y or Tòwn, St	ate)	or Rural Route Number,
ledical	29a. Certifier (Check only one)	2 ☐ Medical E		best of my kno asis of examina ner stated.	wledge, dea ition and/or i	nvestigation, in my	opinion, death	place, and due n occurred at th	ne time, date	and place, and	due to the cause(s)
Σ	29b. Signature and	Pen	Clans	Tech	rea	w l	se number 1852			Date signed (A	Month, Day, Year) 11 , 2007
			who completed caus.	203 Que	ensbur		Hyatts	ville,	Maryla	nd 20	781
ate	OCT 12	th, Day, Year)	J. 32. R	egistrar's Signa	iture						

			Please	Type or Prin						-		.egible.	
			For	State of Ma	ıryland		partment of H			ntal Hyg	giene		
			State Registrar			С	ertificate of	Death	7	F	Reg. No.	2007	31511
U	Physicia	an	1. Decedent's Name (First, Middle, Las	st)						Date of Dea Month		Year	3. Time of Death
15	/Medic		Grace Smith							Ctobe	_		1348 M
)	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, o					County of Deat	
18	4 4		Anne Arundel Me 5. Social Security Number 6. S		inte:		Annap  If Under 1 Year			Date of Birtl		ne Art	
	Funeral Director			_ M 2 <b>X</b> □ F	9.	\/	Months Days	Hours	Min.	(Month, Day	/, Year)	12 Mar	nplace (State or Foreign untry) Vland
->			Usual Residence of Decedent		9.	7			1 10	EC 20	) 13	12 1101	. y Lanu
	how at		10a. State 10b. County		10c. City	, Town or	Location						10d. Inside City Limits
	e Ma 3a-f s	cto ]	Maryland Anne A	rundel	An	napo	lis						†X∏Yes 2 No
	or 24	Directo	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Co	untry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ther the Medical Examiner must be notified at	ral	1030 Cedar Rid	<del></del>			2140					SA	
	er de Item	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		5. 1	<ol> <li>Was Decedent of H If Yes, specify Cub.</li> </ol>	lispanic Oi an, Mexica	ingin? (Specifi an, Puerto Ric	y Yes or No- an, etc.)	. 1	<ol> <li>Race - Amer Black, White</li> </ol>	
36	rs aft	by F	1 Never Married 2 Married 3 Nover Married 2 Married	1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	Ю		1 □ Yes 🏖 No	Specify	<i>y</i> :			Specify: B1	Lack
ခို	2 hou atura cal E	bel	15. Decedent's Ed	ducation		16a. De	cedent's Usual Occup	ation			16b. Kin	d of Business/	industry
215	hin 7: an "n Medi	ple	(Specify only highest gra	ade completed)  College (1-4or 5-	+)	(G.	ive kind of work done e. DO NOT use retire	during mo d)	st of working				
2	giene giene er the	Completed	8th	0	,	H	lousewife				No	ne	
D D	tal Hygir d other event, til	Be (	17. Father's Name (First, Middle, Last)						ner's Name (F			Surname)	
<u> </u>	should be and Mental marked o	ို	Golden Nickels						nces				
Baltimore, Maryland 21215-0036	0 0 0 0		19a. Informant's Name/Relationship (			l	ailing Address (Street						
e,	1 and 2 Health em 27 i		Frances Goins(	Daughter)					Dr.			ille,	Md. 20747
وّ	Pages on the control of the control		1 X Burial 2 ☐ Cremation 3 ☐		Men	metery, o	s <b>nost</b> ion <b>Warte if O</b> crematory or other pla al Park	ija 1	10-12			rel, N	•
<u>=</u>			4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer	• •	110	OL I	Williame Revoks	100					
Ba	permit. Departr Importa any Inji		21. Signature of Funeral Service Licer	)			821 West				-		
			23a. Part1. Enter the disease, or com	plications that caused	the death	. Do not				-		Q. ZI	Approximate
ı,	Dhysisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	e.								Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	ast		ancer						7 years
8	Examiner												
-		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequ	ence of):							-
	cutec nd ransi	Examiner	that initiated events	C									
60,	be executed sician and burial-transit		resulting in death) Last	Due to (or as	a consequ	ence of):							
	death certificate b attending physic	Physician/Medical		d									
9 ×	ding page as	/Me	IF FEMALE:	23c. If yes, outcome	of progna	201							
Box	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 ☐ Fetal	death	3 ☐Ectopic pregnanc 5 ☐ Other (specify) _	У			2	3d. Date of del Month	ivery Day Year
oj.	the d y the ched	isic	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown	une or ac	Jan	o line (specify)						
ם.	s that ned b deta	by Pr	Part II. Other significant conditions	contributing to death bu	t not resu	Iting in the	e underlying cause giv	en in Part	11.	23e. Did to	obacco us	se contribute to	the cause of death?
Vital Records,	The law requires that the death certificate the has been signed by the attending phys age 2 should be detached for use as the									1 🗆 Y	res 2	No 3□Pr	obably 4 Unknown
ပ္တ	aw re us bee	Completed								24a. Was		24b. Were au	topsy findings available
		mo;								autop perto 1∐ Yes	rmed? 2 No	death?	completion of cause of
Ita	sician: The law certificate has b irector, page 2 s	Be C	25. Was case referred to medical examiner?					26. Plac	ce of Death (C		+		
7	Physic this ca	L <sub>O</sub>	1 Yes 2 No	/		ER/Outpa	tient 3 DOA Oth	4 🗆 N	Nursing Home	5 🗆 Resid	dence 6	□Other (Spe	cify)
ב	ing Pt After tt uneral	on:	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injui (Month, Day		28b. Tim Inju	ry Wor			d. Describe h	now injury	occurred	
SIC	ttend death stor: /	cati	2 Accident investigation 3 Suicide 6 Could not be		uni Atho	ma farm		Yes 2		1 1	24 4	/N	-15-1-11
Division or	fospital or Attending P I hours after death. 'uneral Director: After t ely filled in by the funera	Certification:	4 ☐ Homicide determined	building, etc	. (Specify	r)	street, factory, office		281	City or Tox			ural Route Number,
	spital ours neral filled		29a. Certifier Certifying Ph	nysician: To the best of	of my know	wledge, de	eath occurred at the ti	me, date a	and place, and	d due to the	cause(s)	and manner as	s stated.
	* N F 2	edical	(Check only	miner: On the basis of and manner sta	examinat	ion and/o	r investigation, in my	opinion, de	eath occurred	at the time,	date and	place, and due	e to the cause(s)
	To the within 2 To the сопре	Me	29b. Signature and title of certifier				29c. Licens					e signed (Mont	
			Janua une	em, MD			1)3	283	30	1	DCF	sper8	,2007
0	all				eath (Item	23a) (Ty	pe, Print)	. 4		1.0		3	/
	CH		JEUNINE WEINE	1 MU 40013	KSTG	9th	sad # 53	1 /	nnopo	113, N	IV a	21401	
	Sta Registr		30. Name and address of person who Jeanine Werner 31. Date filed (Month, Day, Year)  OCT 102	2007 Sz. Zgistra	ars Signai	K	break ,						
DHI	MH 17 Bey 1/2		001 1 0 2	.001	-								

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

1 5 2007

32. Registrar's Signature

07-07988 Andre Trinh

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	F	- For State		Cen	tificate o	f Death		75	Reg. No.	200	7 3451
Physicia ledical Examin	1/	<ol> <li>Decedent's Name (First, Middle,L</li> </ol>	ast) ire NMN	TRIN	111			2. Date of D Month	Day	Year	3. Time of Death 0045 hrs
Euicai Examini		4a. Facility Name (if not institution,				4b. City, Town, or L	ocation of Deat		13, 2007 4c. C	ounty of Death	
		Northbound Route 270 a				Clarksburg				ntgomery	
Funeral	T	Social Security Number     6.	Sex 7. Ag	ge (In yrs. Ia	•	If Under 1 Year Months Days	If Under 24Hrs Hours Mir	_	,	/YYYY) 9. Birth Foreign	
Director			X M 2 F		57 Yrs		110010	Feb.	22,19	50 Cou	<sup>ntry)</sup> Vietnam
any	-	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loca	tion		-			10d. Inside City Limits
<b>≜</b> .₁		Maryland Washin	gton	Hage	erstow	n					1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number		<u> </u>		10f. Zip Code			10g. Citizer	of What Count	ry?
ith the Maryland 23a or 28a-f sho notified at once.		10914 Bayberry (	Court			2174	40		τ	J.S.A.	
th with	uneral	11. Marital Status  1 Never Married 2 X Marri	12. Was Deceden Armed Forces			as Decedent of Hisp Yes, specify Cuban,			No- 14	. Race - Americ White, etc.	an Indian, Black,
er dea	<u> </u>		1 Yes 2 red If Yes, Give Year	X No	1	Yes 2 X No	specify:		Sc	ecify:	Asian
urs aft tural'	함	15. Decedent's Education (Specify	or Dates:	mpleted)	16a. Decede	nt's Usual Occupation	on (Give kind of			d of Business/In	
6 72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	_	nost of working life. I	DO NO Luse re	tired)			
5-0036 iled within 7. Hygiene. I other than		12 17. Father's Name (First, Middle, La	0		pizz	a worker	8.Mother's Nam	e (Eiret Middl	1 -	LZZA	
215- be filed ntal Hyg rked of	Be C		Trinh Vanl	Hun			o.Motrier 3 (42m			Chi Kier	1
21215-0036 hould be filed within 7- nd Mental Hygiene. is marked other than ttic event, the Medical		19a. Informant's Name/Relationship			4	g Address (Street			-		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shingury or other traumatic event, the Medical Examiner must be notified at once	L		- wife	Too. 5		Bayberry				Maryla	
ore, es l ar of Hez	П	20a. Method of Disposition  1 Burial 2 X Cremation	3 Removal from S	tate c	rematory or o	ther place)	- ^	Date		·	
Baltimore, permit Pages I an Department of He Important: If ite	1	4 Donation 5 Other Spec		Hag		on Cremato	-			gerstown ral Hom	n, Maryland
Balti permit Departm Imports injury o		21. Signature of Funeral Service Lic	censee								land 21740
Physician	+	23a. Part I. Enter the disease, or co		d the death.							Approximate Interval Between Onset and
/Medical 'xaminer	1	failure. List only one cause on Immediate Cause (Final disease	a. Multiple Injurie:	S							Death
	-	or condition resulting in death)	Due to (or as a cons	sequence of	·):						
	<u></u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	sequence of	·):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of	):						
recuted n and - transit		events resulting in death, Last	d								
<u> </u>	Medical	UNPENDED	AMENDED								
3760, ificate be g physici s the buri	Ĭ	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	ome of pregr		etal death 3	Ectopic pregr	nancv		Date of delivery lonth D	ay Year
ox 687 eath certific	sician/	past 12 months?	4 Pregnant a	at time of dea	oth	other (Specify)	, , , ,				
J. Box t the death c by the atten	ᇍ	Part II. Other significant condition	9 Unknown	ith but not re	esulting in the	underlying cause di	iven in Part I	23e. D	id tobacco us	e contribute to t	the cause of death?
P.O. res that the signed be detacted	≦	artin outs organization	io benung to doc		odining in the	andonying cause g		1	Yes 2	No 3 Prob	ably 4 Unknown
rds, requir been s	Completed							24a. W	/as an utopsy		topsy findings available ompletion of cause of
ecol he law ite has					-			p	erformed?	death?	,
Vital Rec ysician: The his certificate director, page	ابه	25. Was case referred to medical					of Death (Check				
of Vital Records,  ng Physician: The law requin  ther this certificate has been si meral director, page 2 should be	B 일	examiner? 1 ✓ Yes 2 No		ient 2	ER/Outpatier			ing Home 5		ce 6 🗸 Other	Scene
Division of Vital Records, P.O. Box 68:  10 spital or Attending Physician: The law requires that the death certif.  12 hours after death  13 Fineral Director: After this certificate has been signed by the attending tell filled in by the funeral director, page 2 should be detached for use as		27. Manner of Death  1 Natural 5 Pending	28a. Date of In (Month, Day Oct 13, 200	jury Year)	28b. Time of 0037 hrs		y at Work? es 2 ✔ No		ibe how injury ito <mark>auto c</mark> o		
Division tall or Attending afformation all Directors / led in by the fi	g	2 🗸 Accident Investig	gation 28e Place of I	Injury - At ho	ome, farm, stre	eet, factory, office bu					ral Route Number, City
Divipital or ours after all Divipited in	Certification:	3 Suicide 6 Could r 4 Homicide determi		terstate/E	Express			or Tow Northboun	n, State) id Rte 270 a	it Rte 121, Cla	arksburg, MD
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier 1 Certifying Physone) 2 ✓ Medical Exami	sician: To the best of r	amination a	ge, death occu nd/or investiga	urred at the time, dat ation, in my opinion,	te and place, ar death occurred	nd due to the d I at the time, d	cause(s) and late and place	manner as state e, and due to the	ed. e cause(s)
To To Col	ĕ⊢	29b. Signature and litle of certifier	and manner stated	1.		29c. License	e number		29d. Da	ate signed (Mor	ith, Day, Year)
		11/1				O.C.N	<b>Л</b> .Е.		Octob	per 13, 2007	·
5H-2 00	ME	30. Name and porress of person with Mary GA Ripple MD.	Deputy Chief Med			1 Penn Street,	Baltimore,	MD 21201			-
Sta	te	31. Date filed (Monto CT Yelr) 5	2007 32. Registr	ar's Signatu	re A	all)		•	•		
Registi	હા				11						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 11:25 PM 10 4 2007 Iruluck Jonovan 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Arnold Anne Arundel 313 Alameda Parkway 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number Days Months 1**⊠** M 2□ F 1, 1926 80 South Carolina Dec. 250-30-7072 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count Arnold Maryland Anne Arundel 1 ☐ Yes 2 XXXIO 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21012 U.S.A. 313 Alameda Parkway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S.
Armed Forces?
1 ★ Yes 2 □ No
If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 Never Married 2014 Married White 1 ☐ Yes 2000 No Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Commercial College (1-4or 5+) Elementary/Secondary (0-12) Carpenter Construction 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mack Arthur Truluck Ruby W. Player 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 313 Alameda Parkway Arnold, Maryland Hazel L. Truluck/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/9/2007 Baltimore, Maryland Baltimore Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 ao 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Me Interstita disease or condition resulting in death) Due to (or as a consequence of): Ashistosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 🗆 No

**Physician** /Medical Examiner

and

attending physician

the

page 2 s

filled in by the funeral

Be

Certification: To

Medical

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

within 24 hours a To the Funeral L

as the

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once.

**Physician** 

/Medical

Examiner

Funeral

Director

show

iral", or items 23a or 28a-f shov Examiner must be notified at

Pages 1 and 2 should be filled within 72 hours after onent of Health and Mental Hygiene.

Int. If Item 27 is marked other than "natural", or iten any or other traumatic event, the Medical Examiner.

Baltimore, Maryland 21215-0036

death with

Director

Funeral

Completed by

Be

2

Examiner Physician/Medical Completed by

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

5 ☐ Pending investigation 6 ☐ Could not be determined

2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only

2 ☐ Accident

3□ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/states 29b. Signature and the le of cartifle

9c. License numbe

29d. Date signed (Month, Day, Year)

10/3/2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

s of person who completed cause of death (Item 23a) (Type, Print) and addr.

Greene St., Bathmare, MD 21201

State

Registrar

°1 2007

egistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: ithin 24 hours after death.

o the Funeral Director: A
ompletely filled in by the fu

within 24 12

Medical

To the I

31. Date filed (Month, Day, Year) State 1 2 2007 Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

M.D 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

07-07777			ease Ty	pe or Print	in Bla	ack Ind	lelible	Ink. E	nsure	e All Co	opies A	Are Le	gible.	000	07 0	J pres 1
Nathaniel Sylves		l aylor 1- For State	St	ate of Mary	land /		tment d ificate d			a ivient	аі пуді		aa Na	201	07 3	45
Physicia		Registrar  1. Decedent's Nam	e (First, Midd	le,Last)								ate of Dea	eg. No. th Day	Year	3. Time of De	
"cal Examin	ner			VESTER TA							0	ctober 5	, 2007		1337 hrs	S
		4a. Facility Name ( 1519 Stride		on, give street and	number)			4b. City,		Location of	f Death			County of Dea ine Arunde		
Funeral		5. Social Security I	Number	6. Sex	7. Age	e (In yrs. las	st birthday)		der 1 Yea			Date of Bir	th (MM/D	D/YYYY) 9. B Fore	irthplace (State	or
Director		577 66 0	0065	1 X M 2 F			59 Y	rs. Mont	hs Day	s Hours	Min.	08/31	/194		Country) DC	
'n		Usual Residence of	of Decedent 10b. County			10c. City. T	own or Loc	ation							10d. Inside C	City Limits
d how ar		MD	1	ARUNDEL			OVER								1 X Yes	2 No
arylan	Director	10e. Street and Nu		INCHEL	_			10f. Zi	p Code			1	-	en of What Co		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1519 STF	RIDER (	COURT				2	21076	5			_	TED ST		
th with	Funeral	11. Marital Status	ied 2 X M		ecedent Forces?	Ever in U.S					in? ( Specif Puerto Rica		)- 1	<ol> <li>Race - Ame White, etc.</li> </ol>	erican Indian, Bl	ack,
er deat		3 Widowed		1 X Yes	2 Year	No	1	Yes	2 <b>V</b> No	specify:			s	Specify: B	LACK	
urs afte	Completed by			or Dates: ecify only highest g		npleted)	16a. Deced	lent's Usua	Occupa	tion (Give k	kind of work			nd of Busines		
5 72 ho na "na ral Ex	lete	Elementary/Sec	condary (0-12	) College	(1-4 or					. (	use retired) GOVER1				PARTMENT	OF
5-0036 led within 7 Hygiene I other than	Jmp			2+			MILII	CARY I	POLIC	CE /	POL Is Name (Fir	CE_	ARI Maiden S		REASURY	
215-1 be filed ntal Hyg rrked oth	Be C	17. Father's Name	`								RGIA N			, ,		
212 buld be I Ment mark ic ever	To E			ship (Type, Print)						et and Num	ber or Rura	Route Nu	mber, Cit	y or Town, Sta	ite, Zip Code)	
MD id 2 sho lith and in 27 is		NGA KIM		R / SPOUS	SE	Tan a		STRI				OVER,		21076	or Town, State	
altimore, mit. Pages I an partment of Hea pportant: If iter iury or other tri		20a. Method of Di		on 3 Remova	I from St	ate c	lace of Disp rematory or	other plac	e)							
time L. Page tment rtant:		4 Donation				ARL	INGTO				10/30		_		TON, VA	
Bal permi Depar Impo	1	21 Signature of F	uneral Servic	e ncensee			- 1	MARS	HALL	S FU	NERAL ROAD	HOME	OF I	MARYLAN ND, MD	ND, INC.	
Physician		23a. art I. Enter	the disease, o	or complications that	at caused	the death.	Do not ente	er the mode	e of dying	, such as c	ardiac or re	spiratory a	rest, sho	ck, or heart	Approxima	ate Interval Onset and
/ Medical ≟xaminer		Immediate Cause	•	e on each line. e a. Contact	Gunsh	ot Woun	d of Hea	d								eath
_Xaiiiiiei		or condition result	ting in death)	Due to (or a	s a cons	equence of	):									
	er	Sequentially list of if any, leading to	immediate	Due to (or a	is a cons	equence of	):									
	Examine	(Disease or injury events resulting in	that initiated	C.	s a cons	equence of	):	_	_	_	_				-	
cecuted n and - transit	alEx	events resulting it	ii dealii) Lasi	d												
be exe		UNPENDE	D	AMENDE	D				_							
Box 68760,  death certificate be ex the attending physician ed for use as the burial	cian/Medio	IF FEMALE: 23b. Was deceder		AL-	es, outco e birth	me of pregr	nancy	Fetal deal	th 3	Ectopi	c pregnancy	/	230	<ol> <li>Date of deliving</li> <li>Month</li> </ol>	very Day	Year
X 68 th certi ttendin r use a	sicia	past 12 month		4 Pr		t time of dea	ath 5	Other (S					1			
. Bo he dea y the a	Phys	1 Yes 2		Inknown g Ur Iitions contributir	nknown	th but not re	sulting in th	ne underlyi	ing cause	aiven in Pa	art I.	23e. Did	tobacco	use contribute	to the cause of	death?
cords, P.O. Bilaw requires that the de has been signed by the	þ	Part II. Other sig	imican con	ntions contributi	ig to dea	in par nor re	Journa III II	io diladiny.	9 02200	givenini		1Y	es 2 🗸	No 3 F	Probably 4	Unknown
ds, equire een sij	Completed											24a. Wa	s an opsy	24b. Were	e autopsy finding to completion of	s available
e law i e has k	ldm												formed?	death	1?	No
II Re in: Th rtificat tor, pag	e Co	25. Was case refe	erred to medi	cal		Y. 1			26.Pla	ce of Death	(Check onl					
Vita hysicia this ce I direct	0 8	examiner?	2 No	Hospital: 1	Inpati	ent 2	ER/Outpat	ient 3	DOA	Other <sub>4</sub>	Nursing			ence 6 🗸 O	ther: Scene	
n of Vital Rec ding Physician: The I After this certificate I funeral director, page	n: T	27. Manner of De 1 Natural		FO(Y	ate of Indone	jury Year)	28b. Time FOUND:		_	jury at Worl	- İsı	3d. Describ ubject sh		ury occurred		
Sion Attend r death r death by the	catio	2 Accident		ending Oct	5, 2007	njury - At he	0600 hrs					Bf. Location	(Street a	and Number or	Rural Route No	umber, City
Division of Vital Records, P.O. rat or Attending Physician: The law requires that thr safter death.  The Insert of the this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	3 ✓ Suicide 4 Homicide	de	ula not be		ngle Fan			,,_,,,			or Town	State)	nover, MD		
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the funeral director, page 2 should be detached for use as the burial - transition of the funeral director, page 2 should be detached for use as the burial - transition of the funeral director, page 2 should be detached for use as the burial - transition of the funeral director.		29a. Certifier (Check only	Certifying	Physician: To the	best of r	nv knowled	ge, death o	ccurred at	the time,	date and pl	lace, and du	e to the ca	use(s) ar	nd manner as	stated.	Section 1.0
Fo the vithin Fo the complete	Medical	one) 2	0	xaminer: On the ba	sis of ex er stated	amination a	nd/or inves					ne time, da				arl
	Ž	29b. Signature ar	nd title of cert	ifier						nse number C.M.E.				ober 6, 20	(Month, Day,Yea <b>07</b>	ar )
OGME			1/		1	domin (11 -	230)			✓· 1¥1. L·						
(M) AP		30. Name and ad Mary G. R	1/	oń who completed Deputy Chi				111 Per	n Stree	et, Baltin	nore, MD	21201				
S	tate		V	ar) ha 32	. Regist	ar's Sio et	Chi									

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#5per:INF10/18/07, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 рМ October 9, 3:10 Domenica Vezzi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3347 S. Leisure World Blvd. Silver Spring Montgomery 8. Date of Birth (Month, Day, Yea July 5, 1929 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 579<sup>1</sup>42<sup>1</sup>6813 6. Sex **Funeral** 1□ M 21 F Months Days Hours 78 Washington, DC Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show an "natural", or Items 23a or 28a-f sho Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3347 S. Leisure World Blvd. 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the Homemaker Own Home traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event once. Be Anthony Todaro Mary Stewart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Vezzi/Husband 3347 S. Leisure World Blvd., Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 15. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2007 Silver Spring, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licence Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Ovarian Cancer 18 Months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its today or injury Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ned by the a 1 ☐ Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signe be a δ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy performed? Be

Division or Vital Records, or Attending Physician: this funeral after death.

I Director: Af d in by the fur filled in by Hospital

ပ Certification:

Medical

within 24 hours a

To the

		1	l Ýes 2 No 1 Yes 2 No						
25. Was case referred to medical		26. Place of Death (Che	eck only one)						
examiner? 1 ☐ Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DO/	Other: 4 Nursing Home 5	lome 5 🛱 Residence 6 🗆 Other (Specify)						
27. Manner of Death  1  Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury  M	(Month, Day Year) Injury Work?							
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, building, etc. (Specify)	office 28f. Lc	ocation (Street and Number or Rural Route Number oity or Town, State)	r,					
	sician: To the best of my knowledge, death occurred a ner: On the basis of examination and/or investigation,								

29b. Signature and title of certifier

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

October 10,2007

D60335

Banne MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18111 Prince Philip Drive, #327, Olney, MD 20832 Paul Bannen, M.D.

and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

2007



			For State Registrar	State of M	aryland		artment rtificate			and Me	ental Hy	giene Reg. No.	2007	34518
	Physici	an	1. Decedent's Name (First, Middle, Las. Erminia G.								2. Date of De Month October	ath Day 3	/ Year 2007	3. Time of Death 2:05 aM
	/Medic		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o		octobel		County of Dea	
			13331 Signal Tre				W112-32	Poto		34 (1 1			Montgo	
	Funeral Director		5. Social Security Number 6. Se 1[	x	ge (In yrs. Ia 56	St birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	3. Date of Bird (Month, Da	y, Year)	C	thplace (State or Foreign ountry)
			Usual Residence of Decedent		40- 0:5	T					Nov. 25	), L	950 E1	Salvador
	f shoved at	ō	10a. State 10b. County Maryland Montgome	rv	Poto	Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2☐ No
	n 18a-	Director	10e. Street and Number				10f. Zip	Code				10g. Citi	izen of What C	1
	ath wit		13331 Signal Tree						0854			Ų1	nited S	tates
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medi-al Examiner must be notified at ance.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces?  1  Yes 2 If Yes, Give Year or Dates:	,						ify Yes or No ican, etc.) .alvado		14. Race - Ame Black, Whi Specify: Hi	te, etc.
Baltimore, Maryland 21215-0036	within 72 ho ene. than "natui he Mediral	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or	5+)	16a. Deced (Give life. I	dent's Usua kind of wor DO NOT us ewife	il Occupa k done d e retired,	ation luring most )	of working	9		ind of Business Home	/Industry
d 2	e filed al Hygi other vent, t	Be	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name (	First, Middle,			
ylar	ould by Mental	일	Luis Galeas	-					Luis					
Mar	nd 2 sh Ith and 27 is m traum		19a. Informant's Name/Relationship (7) Isidoro Vasquez -	. ,									or Town, State, MD 208	•
re,	ss 1 ar of Hea item ?		20a. Method of Disposition		1 00	ace of Dispo	sition (Nam	ne of		0/12/			ocation - City or	
timo	Page tment tant: It jury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	)	'	t Line	coln (	rema	atoriv			Bren	ntwood,	MD
Bal	permit Depar Impor any In		21. Signature of Fune al Service Licens	D Mad	), _	1.0	2. Name and	d Addres	s of Facility	y Simp	le Tri	bute	e, MD 20	2050
6	10		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	dications that cause	d ne death.								e, MD 20	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	120										Onset and Death One Year
	/Medical Examiner		resulting in death)	a. Castr Due to (or as	a conseque	ence off:		24						
B	- t = 2	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Chase process process of injury that initiated events	b Due to (or as	a conseque	ence of):								
	ecuter and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a cancague	ance of:								
8760,	cate be executed ohysician and the burial-transit	dical E		d	a conseque	ence or).								
89	rtificate ng phy as the	Medic	IF FEMALE:	u										
Вох	eath certific attending p for use as f	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth 4□Pregnant a	2 Fetal	death 3□	Ectopic pro					10	23d. Date of de Month	elivery Day Year
P.O.	that the de ned by the a detached f	hysic	1  Yes 2  No 9  Unknown N	9☐Unknown	it time of de	atn 5L	Other (sp	eciny)						
Division or Vital Records, P	e g	þ	Part II. Other significant conditions co	ontributing to death b	out not resul	ting in the u	nderlying ca	ause give	en in Part I.		23e. Did t			to the cause of death?  Probably 4 Unknown
eco	law requir as been si 2 should I	Completed								,	24a. Was		24b. Were a	utopsy findings available completion of cause of
a R	iyslcian: The is certificate hadirector, page	Com									perfo 1 Yes	rmed?	death?	·_
Vit	rslcian: Th s certificate lirector, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2☐ No	Hospital:	ent 2 🗆 E	R/Outpatier	nt 3 DO	Othe	r.		Check only o		о Поч <i>(</i> 2)	
n or	ing Phys 1. After this funeral di	n: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju	ury	28b. Time o		8c. Injury Work			d. Describe		6 ☐Other (Sparry occurred	еспу)
isio	ttendil death. stor: A	icatic	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of inj	iun. At hon		М	1 🗆 \	∕es 2 🗆 l		M. I. anation /	Canada -	ad \$1	2 - 1 O- 4- M
É	al or A s after il Direct d in by	Certification:	4 Homicide determined	building, e	tc. (Specify)	)	eer, ractory	, onice		20	City or To	wn, State	ia Number or F e)	Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral	Medical C	29a. Certifier 1 XCertifying Phyone 2 Medical Exam	/slcian: To the best iner: On the basis of and manner st	of examinati	rledge, deat on and/or in	h occurred vestigation,	at the tin	ne, date an pinion, dea	id place, ar	nd due to the d at the time,	cause(s date an	) and manner a d place, and du	as stated. ue to the cause(s)
_	To the within To the complete	Me	29b. Signature and title of certifier	, 0.			1		number			29d. Da	te signed (Mor	nth, Day, Year)
L	f		1 puch 1,0	e Vite	_,	MD			330		,	0cto	ber 9,	2007
			30. Name and address of person who o	completed cause of c	death (Item :	23a) (Type,	Print) An	drew	Putn	am, N	M.D.			
	Sta		31. Date filed (Month, Day, Year)	32. Segisti	rar's Signati	re	2000/							
	Regist	ar	OCT 12 20	JUI Male	w to	5 /5	AL PARTY							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** James Vernon We1ch October 2007 РМ 6:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 12708 Eldrid Place Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**X** M 2 □ F Director 220-09-6623 88 Jan. 11, 1919 Washington, DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12708 Eldrid Place 20904 United States 7 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -11. Marital Status American Indian. Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW—II 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No. Specify: Completed by Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney Department of Justice permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ James William Welch Sarah Olive Dyson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Log House Court, Gaithersburg, MD 20882 9812 Jamie Jackson / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Lincoln Crematory 10/15/2007 Brentwood, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate of e (Final disease or condition resulting in death)

Senile dementia of Alzheimers 1040 Rockville Pike, Rockville, Maryland 20852 Approximate Interval Between Onset and Death **Physician** Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anemia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed Atrial Fibrillation 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe Failure to thrive 1∐ Yes 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🛱 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 😡 Natural 5 Pending Injury investigation 1 Yes 2 No after death 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide e Funeral I 1 Streetifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D33159 Oct. 09, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ruth Kevess Cohen, M.D8700 Georgia Avenue #400, Silver Spring, MD 20910

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

0CT

12

2007

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0000 11, Day 2007 Year Israel WEINSTEIN David 6:50 P. M 4a. Eacility Name (If not institution, give street and number) Suburban Hospital 4b. City, Town, or Location of Death Bethesda 4c. County of Death Montgomery 6. Sex 1 X M 2 ☐ F Age (In yrs. last birthday) 86 Yrs. B. Date of Birth Days, 1920 If Under 1 Year | If Under 24 Hrs. Social Security Number 069-18-8524 9. Birthplace (State or Foreign Days Romania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MDMontgomery Silver Spring 1 ☐ Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1900 Lyttonsville Rd. # 316 U.S.A. 20910 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Hebrew Academy Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Reuben Weinstein Batsheva Auerbach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Weinstein / spouse 1900 Lyttonsville Rd., #316 Silver Spring, MD 20910 Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Eretz Hachaim Cem 1 Burial 2 ☐ Cremation 3 Removal from State Oct.15,2007 Jerusalem, Israel 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Vicenses 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 (drroll St., NW Washington, DC 20012 23a. Part1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septic Shock Duty (ที่ก็ล้างาราชานัก Infection 5 weeks Sequentially list conditions, if any leading to in incident cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Diabetes Years Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Q I Inknown litions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ilure 2 No 3 Probably 4 Unknown 1 Yes Respiratory Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Ves 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner

**Physician** 

/Medical

Director

Be Completed by Funeral

Examiner

**Funeral** 

Director

show

r than "natural", or items 23a or 28a-f shor the Medical Examiner must be notified at

I Hygiene.

permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important: If Item 27 Is marked other any Injury or other traumatic event, the

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner

burial-tran signed by the a To the Hospital or Attending Pl within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral

Vital

0

Division

Meinstein

Physician/Medical Completed by Be Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
Part II. Other significant cond Renal Fai

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe

29b. Signature and title of certifie aw

6 Could not be determined

MD D0051268

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nancy Lawless, 8600 Old Georgetown Rd., Bethesda, MD 20814

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar 31. Date filed (Month, Day, Year) 12 OCT 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** KIMBERLY ANN WEBER 2007 OUT 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE SGURGE LAUREZ INDSPITAL LAUREZ REGIONAZ 8. Date of Birth May 31, Yeag 65 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 213-66-3223 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. MaryTand 1 □ M 2 🗓 F 42 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2 No Maryland Prince George's Laurel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20708 11611 Lighthouse Drive Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify. þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Closings Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nancy Hare Wayne Taylor Thrush, Jr. ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 11611 Lighthouse Drive Laurel, Maryland 20708 Kent J. Weber -husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page:
Department o
Important: If i
any Injury or
once. George Washington Cemetery 10/15/2007 Adelphi,Maryland 4 Donation 5 Dother (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOULE 12 HRS **Physician** /Medical Due to (or as a consequence of) Examiner 24 HRS SEPSIS Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner sician and burial-transit Due to (or as a consequence of) physician the burial attending p as IE FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 X No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to PANCYTSPENIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No METASTATIC BREAT CANZER 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No မှ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

10

1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCT 10, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID O NYMOJOM MD 10724 LITTLE PATURENT PARKWAY mp 21544 COLUMBIA

State Registrar

Medical

31. Date filed (Month, Day, Year)

2007



		-	For State Registrer	State of Marylar		partment of H Certificate of I		ientai Hy	giene Reg. No.	2007	34	522
	Physicia	an	1. Decedent's Name (First, Middle, Las Mary Mae Wood					2. Date of De	ath	007 Year	3. Time	of Death
)	/Medic Examin	_	4a. Facility Name (If not institution, give	street and number)	. 1		Location of Death Frederi		4c.	County of Death		
	Funeral	45	Calvert Memor	ex 7. Age (In yrs.			If Under 24 Hrs. Hours Min.	8 Date of Bir	th	9 Rint	hplace (State	or Foreign
	Director		216-76-5405 1 Usual Residence of Decedent	□ M 2 <b>X</b> 88	Yrs	6.   Working   Buys	Tiodio Timin	May 2	7 19	19   Ma	Tylan	a
	e Marylanda-f show tified at	ctor	Maryland Calve:		ty, Town or ort I	Republic						City Limits s 2 <b>X</b> No
	a or 28	Il Director	10e. Street end Number 2150 Calvert St	treet		10f. Zip Code 2067	6		-	izen of What Co ted St		
036	within 72 hours after death with the Maryland liene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	ī.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ <b>X</b> o	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	)-	14. Race - Ame Black, White Specify:		e
15-0036		leted	15. Decedent's Ed (Specify only highest gra	de completed)	16a. De	ecedent's Usual Occup live kind of work done fe. DO NOT use retired	ation during most of work	ring	16b. K	ind of Business/	Industry	
717	filed within Hygiene. ther than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		memaker				n home	:	
land	eve eve	To Be	17. Father's Name (First, Middle, Last) Edward George				18. Mother's Nam Katie	,	, maiden	Surname)		
, Maryland	ges 1 and 2 should it of Health and Men If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (William W. Wood	dward - son	21!	lailing Address (Street 50 Calver	t St. P	ort Re				6
Baltimore,	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition 1 → Purial 2 → Cremation 3 → 4 → Donation 5 → Other (Specification)	IRemoval from State	-	isposition (Name of crematory or other place Episcop	al Chur	ch	Por	t Repu		Maryla
Ball	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer	a. \		22. Name and Addre	ss of Facility Rau	sch Fu	nera:	l Home	20676	
<u>)</u>	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. CORONA  Due to (or as a consec	th. Do not	enter the mode of dyir	ng, such as cardiac	or respiratory a	arrest,		Approxim Interval B Onset an	etween
	ecuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec								
58/60,	ificate be executed y physician and is the bunal-transit	edical Ex	resulting in death) Last	Due to (or as a consect	quence of)	11 ***						-
P.O. Box 6	eath certif attending for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12.months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	у			23d. Date of del Month	live <b>ry</b> Day	Year
	w requires that the dibeen signed by the should be detached	by	Part II. Other significant conditions	contributing to death but not re-	sulting in th	ne underlying cause giv	ren in Part I.			use contribute to		
Vital Records,		Completed						24a. Was auto perf 1∐ Yes	opsy ormed?	24b. Were au prior to death?	utopsy finding completion of	s available cause of
VITa	siclan: The certificate irector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes	Hospital: 1 ☐ Inpatient 2	D/Outo	otiont 3 DOA Oth	26. Place of Dea			6 □Other (Spe	- 14 - 1	
Division or	ing Phy After this uneral d	tion: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Tin Inju	ne of 28c. Inju		28d. Describe			icity)	
DIVISI	ospital or Attend hours after death uneral Director: ly filled in by the f	Certification:	3 Suicide 6 Could not b determined		nome, farm	, street, factory, office		28f. Location City or To	(Street ar	nd Number or Ri e)	ural Route N	ımber,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (		nysician: To the best of my kn mIner: On the basis of examin and manner stated.								e(s)
•	To the within to the complex c	M	29b. Signature and title of certifier	itending Ph	yric	29c. Licens	19427	7	1	ate signed (Mont	-07	7
(L)	3		30. Name and address of person who ANWAR MUNSMI			PITAL RD.	PRINCE	FRED	)GRI	ak, M.	) 206	78
260	Sta Regist		31. Date filed (Month, Day, Year)  OCT 1	2 2007	nature	4. Specker	,					
	MH 17 Rev 1/2	001										

DHMH 17 Rev 1/2001

٠		,	For State	State of Marylar	,	artment of H			giene	007	34523
s aftr			Registrar  1. Decedent's Name (First, Middle, La	est)		1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Joann	2. Date of Dea	- has	001	3. Time of Death
	Physici /Medic		TERRI WHYTEN					Month 10	05	2007	9:30 A M
100	Examin	er	4a. Facility Name (If not institution, given 7318 POWHATAN ST			4b. City, Town, or LANHAM	Location of Death			ounty of Death NCE GEO	PCFC
15 7	See See and	4		Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	h		place (State or Foreign
6,	Funeral Director			1□M 20XF	35 <sup>Yrs.</sup>	Months Days	Hours Min.	(Month, Da) 11/10/	1971		INGTON, DC
	D > 1		Usual Residence of Decedent  10a. State 10b. County	10c Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
	shov	or				cation					tX Yes 2 □ No
	28a-f	Director	MD PRINCE (	EORGES LAI	MAH	10f. Zip Code			10a. Citize	n of What Cour	ntry?
	3a or	I D	7318 POWHATAN ST	REET		20706			USA		
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. \	Was Decedent of H	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-	14.	Race - Americ Black, White,	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural, or items 23a or 28a-f show aumatic event. If a Medical Examinar must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4XXX ivorced	1  Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Sı	pecify: BLA	
9	tural		15. Decedent's E		16a. Deced	dent's Usual Occup	ation		16b. Kind	of Business/In	dustry
215	hin 72 Bin "ni	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of worki f)	ng			
2	ed wit	Con	11TH		DISAB	LED			NONE		
and	be fift	Be	17. Father's Name (First, Middle, Las RICHARD JORDAN	1)			18. Mother's Name SHARON J		Maiden Su	umame)	
<u> </u>	should of Mer mark matic	ဥ	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	ng Address (Street	and Number or Rura		r, City or T	Гоwп, State, Zip	Code)
ĭ Za	and 2 :	0.000	SHARON CLARK/MOTI	HER	7318	POWHATAN	STREET L	ANHAM, 1	MD 20	706	
Baltimore, Maryland 21215-0036	Pages 1 and the control of the contr	of Lindbrands	20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 [	Removal from State	cemetery, cren	sition (Name of natory or other place	(e)	Date		ition - City or To	
Ē	t. Pag rtmenl rtant: njury	00000	`4 □Donation 5 □ Other (Special	-37		CREMATO	$RY = 10/10$ ss of Facility $J \cdot B$	6/2007			
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev		21. Signature of Funeral Service Lice	dus			VER ROAD				OFTE
ė			23a. Part1. Enter the disease, or con shock, or heart ailure. Vist only	plications that caused the dea	th. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. Paroxysmal	Ventri	cular Tac	chycardia				Onset and Death
3	/Medical Examiner		resulting in death)	Due to (or as a consec		<b>-</b> 6 . •					
	34 A	er	Sequentially list conditions, if any, leading to immediate	b. Acute Myoca  Due to (or as a consec		Infarctio	on	<del>.</del>	<u> </u>		
	be executed sician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Diffuse Con	onary	Atheroscl	lerosis				
Ö,	e exectian an		resulting in death) Last	Due to (or as a consec	quence of):						
8760,	ate the	dlcal	•	d							
9 X	eath certific attending p	√/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn					230	d. Date of delive	erv
. Box	0 0 0	by Physician/Me	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of a		]Ectopic pregnancy ] Other <i>(specify)</i> _	· · · · · · · · · · · · · · · · · · ·			Month	Day Year
0.	that the dended by the a	hys	9 Unknown	9□ Unknown							
	res th igned be de		Part II. Other significant conditions	•	sulting in the u	nderlying cause giv	en in Part I.		bacco use ′es 2 □ I		he cause of death?
O.C	w require been sig should t	eted	Diabetes Mell								
Sec	ela has	Completed	Renal Disease	2				24a. Was autop perfor	an : sy rmed?	prior to co death?	ppsy findings available impletion of cause of
<u></u>		e Co	Cerebrovascu	ar Accident			26. Place of Death		med? 2 No	1 🗆 Yes	ŽE No
₹	ysician: is certific director,	To Be	examiner?	Hospital: 1   Inpatient 2	ER/Outpatien	t 3 DOA Oth	er: 4 Nursing Ho			Other (Specif	(v)
וסר	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury			28d. Describe h			,,
200	endin eath. or: Af	atlo	1 Natural 5 Pending 2 Accident Investigation	on		M 1 🗆	Yes 2 □ No				
Division of Vital Records,	l or Attendater deatl Director:	Certification:	3 Suicide 6 Could not l 4 Homicide determined		iome, farm, str fy)	eet, factory, office		28f. Location (S City or Tow		Number or Rura	al Route Number,
	Hospital 4 hours Funeral ely filled	edical Co		hysician: To the best of my kni miner: On the basis of examinated and manner stated.							
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	Duitag ?	MO	29c. Licens				signed ( <i>Month</i> , 09/2007	Day, Year)
	0		30. Name and address of person who	completed cause of death (Ite.	m 23a) (Type,	Print)					
	SHC.		RAVINDER RUSTAGI			CHEVERLY,	MD 20785		W		***
	Sta Registr		OCT 1 2 2007	32. Registrar's Sign	ature						

DHMH 17 Rev 1/2001

			For 1_ State	State of Marylan				d Mer	ntal Hyg	iene		- 1	0.1
			Registrar	net)	Cei	rtificate of	Death	2	Date of Deat	eg. No. 20	0.7	31	524
F	Physici		1. Decedent's Name (First, Middle, Las Harold	M •	Yo	oung			Month ctober	Day	Year 007	2:00	A M
erit Vicin	/Medio		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	r Location of D	eath		4c. County	of Death		
			3008 Sunset Lane			Suitla				Princ	e Ge	orge's	3
l	Funeral Director	74	5. Social Security Number 6. S 252-74-1669	ex 7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Vlin. Ma	Date of Birth (Month, Day, arch 2	<sup>Year)</sup> 5 1946	Coui	lace (State try) rgia	or Foreign
	pu ,		Usual Residence of Decedent	10° Cib	v. Town or Lo	action						0d. Inside 0	Pite Limite
	anylar show	-	10a. State 10b. County			cauon							S 2 No
	he M 28a-f otifle	Director	Md Prince (	George's Su	itland	10f. Zip Code				0g. Citizen of	What Cour		
	a or	Ö	3008 Sunset Lane								What ood	idy:	
	leath ns 23 must	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	20746 Was Decedent of H If Yes, specify Cuba	lispanic Origin'	? (Specify	Yes or No-	USA 14. Rad	ce - Americ	an Indian,	
36	be filed within 72 hours after death with the Maryland thal Hyglene. Indicate than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fun	1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	Armed Forces?  1 X Yes 2 □ No / If Yes, Give Year or Dates:	rmv	If Yes, specify Cuba 1 ☐ Yes 2€ No	an', Mexican', P Specify:	uèrto Ric	an, etc.)		ck, White, <sub>fy:</sub> Bla	_	
Š	2 hou natura ical E	ted	15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occup	ation	. unrkina		16b. Kind of B	usiness/In	dustry	
2	thin 7 e. an "r Med	ple	(Specify only highest gra	College (1-4or 5+)		kind of work done DO NOT use retired	duning most of d)	working					
2	ed wi yglen yer th	Completed		4 yrs	Ins	taller	40.44.4			Priv			
and T	d d d	Be	17. Father's Name (First, Middle, Last) Alfred Young	1				,	Baker Baker	Maiden Surnai	ne)		
$\frac{8}{2}$	should ind Men marke	70	19a. Informant's Name/Relationship (	Tuno Print)	10b Mailie	ng Address (Street					Stato Zir	Code 20	747
Ma	d 2 s th an 17 is traun		Sharon Young/Da			Winter G							and
ē,	tem 27 tem 27 other tr		20a. Method of Disposition			esition (Name of matory or other place		Date		20c. Location			
Ë	Pages nent of int: If it		1 🗷 Burial 2 □ Cremation 3 □ 4 □ Donation 🦠 □ Other (Specification )	Hemoval from State		ans Cemet		-15-	2007 C	heltenh	ıam,	Maryla	and
Baltımore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once.		21. Signature of Suneral Service Licer		2:	2. Name and Addre	ss of Facility	J. 1	B. Jen	kins Fu	inera	I Home	3
n	a E E		Par 14			7474 Land	lover R	oad :	Landov	er,Mary	yland	20785	5
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	n. Do not en	ter the mode of dyir	ng, such as car	rdiac or re	espiratory arr	est,		Approxima Interval Be Onset and	etween
No.	Physician		Immediate Cause (Final disease or condition	a. Esophaoea	al Can	cer						Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as a consequent									
		-	Sequentially list conditions,	b Due to (or as a consequ	nence of).								-
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	240 10 (01 40 4 001.004)	aoi.ioo o.j.								
,	execunand and all-tra	Exal	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):								
8760	cate be executed physician and the burial-transit	dical	•	d									
Ó	certifica nding ph		IF FEMALE:										
ROX	leath certific attending p for use as	an/J	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta		☐Ectopic pregnancy	y				ate of deliv	ery Day	Year
	The law requires that the death the has been signed by the atter bage 2 should be detached for u	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5	Other (specify) _					OTHE	Duy	Tour
, О.	res that the de signed by the a be detached		Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco use con	tribute to t	he cause of	death?
Vital Records,	quires n sign ald be	d by						_	1 🗆 Y	es 2 No	3 ☐ Pro	abiy 4X	]Unknown
ပ္ပ	aw require s been si s should t	Completed							24a. Was a		Were auto	psy finding	s available
ř	The lay	шо						_	autops perfor 1 Yes	med? 2 No	pnor to co death? 1  Yes	mpletion of 2√⊡ No	cause or
<u>ra</u>	ilclan: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of	Death (C	heck only or			-A	
	Physic this ce al direc	ToE	1 Yes 2 No	Hospital: 1   Inpatient 2	ER/Outpatie		4 🗆 Nursii	ng Home	5X Resid	ence 6 □Ot	her (Speci	fy)	
ב	Attending Physician: r death. ector: After this certific by the funeral director,		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor			I. Describe h	ow injury occu	rred		
<u>S</u>	ttend death.	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ome form et		Yes 2 □ No	_	Location /S	treet and Num	har or Pur	I Pouto Nu	mbor
Division or	= 5 # ¢	Certification:	4 ☐ Homicide determined	building, etc. (Specif	y)	reet, ractory, office		201.	City or Tow		ber or nar	ii Noute rea	nnber,
	splta ours eral filled		(Check only 2 Medical Exal	nysician: To the best of my kno niner: On the basis of examina									(s)
	To the Hos within 24 hr To the Fur completely	Medical	one)  29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		2	29d. Date signe	ed (Month.	Day, Year)	
	F3F8		houte	O. Weltz	m	D23	3743			October			
	(10)		30. Name and address of person who	completed cause of death (Item	23a) (Type.	Print)							
	De			M.D. 7525 Gree			ive Gr	eenbe	elt, M	aryland	207	70	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No 2007 1 - State Registrar 20b per fh 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 1:20P M Padie Nelson Brown മയി /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Galtimore 2818 Kennedy Avenue Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 69 213-36-6540 -26-1938 Director filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Pres 2 No Director Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S. A 2818 Kennedy 91918 Avenue Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, Black. White, etc. 1 ☐ Yes 2 ☐ ₩6
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Blac 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Keepino Private 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Moultrice *Nelson* Horence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomasann Jones/Daughter 4806 Frankford Ave. Baltimore MD 21006
ace of Disposition (Name of Date 20c. Location - City or Town, State if item 27 or other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorical Bark 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State Department o important: If any injury or once. 10-23-2007 Windsor Mill, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Adress of Facility Voughn C Greene Funeral Services 4905 York hoad Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Breast Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed and burial-tra Due to (or as a consequence of):  $24 \ell \ell - 2^{-1}$  Division or Vital Records, P.O. Box 68760, physician Physician/Medical the. attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform page certificate 1∐ Yes 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes No No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident Injury To the Funeral Director: A To the Funeral Director: A 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00059325 MO30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steams, Orleans St, #145. Baltimore ered MO 1650 31. Date filed (/

DHMH 17 Rev 1/2001

State Registrar

32. Registrar's Signature

Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 26, 2007 October Bradshaw 6:23 P M Syble Bernice 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 7801 Peninsula Expressway Apt 317 Dundalk If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2 X F North Carolina 227-20-1428 October 17,1921 86 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits Maryland Baltimore Dundalk 1 ☐ Yes 2X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7801 Peninsula Expressway Apt 317 21222 TISA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X If Yes, Give Year or Dates: 2X No 1 ☐ Yes 2 ☐XNo Specify: White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 years Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Janie Garrett Fernie Briamon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7801 Peninsula Expressway Apt, 317, Dundalk, MD. 21222 Raymond Bradshaw Husband 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition October 30 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Memorial 2007 Middle River, MD. 4 ☐ Donation 5 ☐ Other (Specify) na re of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of 7110 Sollers Point Road, 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ta Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an 1∐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work?

Physician /Medical **Examiner** The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

ပ

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

death with

72 hours after

d 2 should be filed within 7; th and Mental Hygiene. 7 Is marked other than "na

s 1 and 2 st of Health ar f Item 27 If or other tr

permit. Pages 1
Department of H
Important: If Itel
any Injury or ott

3altimore, Maryland 21215-0036

burial-trar physician the use as ed by the a detached f signed to certificate has been si rector, page 2 should ! this

P.O. Box 68760,

Division or Vital Records,

Physician/Medical Examiner Be Completed by Certification: To 27. Manner of Death

Medical

Hospital or Attending Physician: 24 hours after death Pruneral Director: filled in by completely within 24

> State Registrar

31. Date filed (Month, Day, Year) 0

1 Natural 2 Accident

3∏ Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

rell

and manner stated.

28a. Date of Injury (Month, Day Year)

D0031 Dundall

Escritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2122

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2112 32. Registrar's Signature

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 Certificate of Death Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) October Roby Emory Beall, Jr. 25,2007 3:55 P 4c. County of Death 4b. City, Town, or Location of Death Baltimore Co. Towson 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) Days Months Hours 1**XX**M 2□F June 28,1930 Maryland 10c. City, Town or Location 10b. County Dundalk Baltimore 10q. Citizen of What Country? 10f. Zip Code United States 21224 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

**Physician** /Medical 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 236-44-5383 Director Usual Residence of Decedent 10d. Inside City Limits show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director "natural", or items 23a or 28a-Maryland 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with the Inent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a-or 28a-or 28a-or yo orther traumatic event, the Medical Examiner must be notify 1022 Dalton Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ares 2 1 No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CBL Trucking Truck Driver 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Day Roby E. Beall, Sr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wife Baltimore, Maryland 21224 Mrs. Carol A. Beall 1022 Dalton Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Hilltop Service Corp. 10/30/2007 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death art1. Enter the disease shock, or heart failure. Immediate Cause (Final week **Physician** disease or condition resulting in death) /Medical Due o (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence off Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an , page 2 s autopsy performed? Jas 2 1 No 2 No certificate 1⊟ Yes Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica After this certification funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 4 Homicide 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier St. Balto. md 2,20x of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause 6701 32. Registrar's Signature 31. Date filed (Month, Day, Yéar) State Registrar

DHMH 17 Rev 1/2001

Me

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 34528

am Bobac		4 Ea	or State	State	e of Maryla	Certi	ificate of	Death		,0	Reg.	No.			
		Dani	strar ecedent's Name	/First Middle I	ast)						Date of Death	ay Yea	ır	3. Time of Death	
hysici		1. D			astj		Dahaa			-   (	Month D October 27,	2007		0214 hrs	
Exam	imer	4-	W11	liam_	give street and nu	mber)	Bobac <sub>4</sub>	b. City, Town, or l	Location of	Death		4c. County			
		4a.	701 Edmons	son Ave. Rr	n. # 3	,	Į.	Catonsville				Baltimo			
					Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under	24Hrs.	8. Date of Birth (	MM/DD/YYYY	g. Birt Foreig	hplace (State or	
Funeral			Social Security N					Months Days	Hours	Min.	6-6-19	15.2		untry) MD	
Director	1	2	12-60-	9021 1	<b>X</b> M 2 F	5.	5 Yrs.			l	0-0-13	7 2			
	7	_	ual Residence of			10c City	Town or Locati	on						10d. Inside City Li	
any	1	10a	a. State	10b. County										1 Yes 2 X	No
nd show	1 5	1	MD	Balti	more	Ca	tonsv:	111e 10f. Zip Code			100	. Citizen of W	hat Cou	ntry?	$\neg$
aryla 8a-f	Director	106	e. Street and Nu	mber				101. Zip Code				,			
death with the Maryland or items 23a or 28a-f show must he notified at once.	吉		701 E	dnonds		nue Rm.		2	1228			U.S.7	Amor	ican Indian, Black,	-+
vith t s 23s	<u> </u>	11.	. Marital Status			cedent Ever in U.	S. 13. Wa	s Decedent of His	spanic Orig n. Mexican.	in? (Spe Puerto R	cify Yes or No- tican, etc.)		te, etc.	icari indiani bidoki	1
eath v item	Funeral	1	X Never Marri	ed 2 Mar	ried Armed F	2 X No						0	Wh	ito	1
ter de			Widowed	4 Divor	ced If Yes, Give Ye	ear	1	Yes 2 X No							
hours after "natural",	<u> </u>	<u> </u>	5. Decedent's E	ducation (Speci	fy only highest gra	ade completed)	16a. Deceder	nt's Usual Occupa	tion (Give i	kind of wo		16b. Kind of E	ousiiiess.	/ilidustry	l
2 hou "nat	<u> </u>		Elementary/Sec			(1-4 or 5+)					<i>'</i>	Dia	- h 1		
36 hin 7 than			5th				D	isabled				Dis		ea	
5-0036 fled within 7. Hygiene.	Completed	17	7. Father's Name	(First, Middle, L	ast)						(First, Middle, M		ne)		1
al Hy	Bo B		Willia			Sr			Do	rot	ny R	olf	Ct+	a Zin Codo)	
212 ald be Ment mark	S S			I/Deletionsh	in (Type Print )			ig Address (Stre							1
Sho and and 27 is	matic	Ī	Villian	n P. Bo	bac Sr	rather_	1 Br	ett Co	<u>urt 1</u>	Apt.	211 I	Balto.	ME D = City (	or Town, State	
y MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. teath and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f she ten 27 is marked other than "natural", or items 40 or 18a-f she terminer must be notified at once	tran	20	Da. Method of Di	sposition		200.	Place of Dispo crematory or o	sition (Name of co	emetery,		Date				
Ore ges 1 t of H	i i	1			3 Removal	from State		Ht. of	Toc	10-	-30-07	Balt	imo	re, MD	
timent trant	0 L	4	Donation  1. Signature of F	5 Other Sp	ecify:	150				у		Fune	ral	Home	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "in		- 1	1//		of second district		_ J	Name and Address of Seph 1	N Za	anni	no Jr.	D-1+0	MI	21224	
		2	30 Part Enter	the disease, or	complications that	t caused the death	h. Do not enter	the mode of dyin	g, such as	cardiac o	r respiratory arr	est, shock, or	heart	Approximate In Between Onse	
ysicia /Medic		1	failure. List	only one cause	on each line. U	pper Gastro	ointestu	Abuse -	uage					Death	
Examin		1	mmediate Cause or condition resul	e (Final disease	a. Compile	s a consequence	1110711001101	710000							
		Ţ			b Due to (or a	S & Consoquence	/-								
		. S	Sequentially list of f any, leading to	conditions, immediate	Due to (or a	s a consequence	of):								
		בַּן	cause. Enter Un Disease or injur	iderlying Cause	c										
1	=	Examiner	events resulting	in death) Last	Due to (or a	s a consequence	of):								
A de die					d										
O, e be execut	burial -	sician/Medical	UNPENDE	ΞD	X AMENDE #23a	perME C87	4. 12/20	<u>/07_TT</u>				23d. Dat	e of deli	verv	
'60 zate b	he bu	اَ	IF FEMALE:	ent programt in t	23c. If ye	es, outcome of pre	egnancy		3 Ector	pic prean	ancy	Mon			еаг
687 ertific	e as t	ug 12	3b. Was decede past 12 mon	iths?		ve birth regnant at time of		Other (Specify)	V			1			
Box 68760, set death certificate be the attending physic	hed for use as the	Sic	1 Yes 2	No 9 Un		nknown	3	Office (chocomy)							
he de	hed f				tions contributir	ng to death but no	t resulting in th	e underlying caus	se given in	Part I.				e to the cause of de	
P.O.	detached	<u>a</u>	, die iii denis de	•							1Y			Probably 4 🗸 Un	
S, F	ld be	8									24a. Wa		4b. Wer	e autopsy findings a to completion of ca	available ause of
w req	shou	흶									per	opsy formed?	deat	h?	No
ecce he la	certificate has been signed by ector, page 2 should be detach	Completed										2 No		Yes 2	
Ω	certific rector, p		25. Was case re	eferred to medic					lace of Dea Other			Desidence	6 1	Other: Scene	
/ita	hıs ce direci	Be	examiner? 1 ✓ Yes	2 No	Hospital: 1	Inpatient 2	ER/Outpat				ing Home 5	e how injury of		other. doore	
of Selling	After tl funeral	2	27. Manner of E		28a. [	Date of Injury Month, Day, Year)	28b. Time	, ,	Injury at W		280. Describ	e now injury c	,00000		
re adi	F. A	<u>.</u>	1 V Natural		nding			, ,	Yes 2					Dural Poute Num	her City
Sic Arte	Director:	ical	2 Accider		estigation 28e.	Place of Injury - A	At home, farm,	street, factory, off	ice building	, etc.	28f. Location or Town	i (Street and I , State)	Number	or Rural Route Num	iber, en
Division of Vital Records, rate or Attending Physician: The law requints after death.	filled in by the	Certification:	3 Suicide	. det	ermined (Spe	ecify)									
lospit Lour	ly fil				Physician: To the	e best of my know	/ledge, death o	ccurred at the tim	ne, date and	place, a	nd due to the ca	ause(s) and m	anner as	s stated.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral I completely filled	Medical	(Check only one) 2	✓ Medical Ex	caminer: On the b	asis of examination	on and/or inves	tigation, in my op	inion, death	occurre	d at the time, da				1
Tot	Com	Med		and title of certi	and man	nner stated.			cense num			29d. Dat	e signed	(MOIIII, Day, rea)	1
			4/1	1 1	.//	MX-		C	C.M.E.			Octob	er 27,	2007	
			1///	me, De	anel.	d source of death !	Item 23a)								
3						d cause of death ( t Medical Exa	miner 1	11 Penn Stree	et, Baltim	ore, N	ID 21201				
				Brassell, MI		32. Re strar's Sig		1 . 10 -							
-		tate	31. Date filed (	(Month OCYT'e	<b>9</b> 2007	SZ. New Jan Son	1	ESTERNI	_						
	legis	trar										OCME			

DHMH 17 Rev 1/2001

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 - State Registrar Amend Items 25,27,28a-f per Certificate of Death Reg. No. Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician PM ARTER 9:50 Helen 12 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ST. Agnes 5. Social Security Number BA A IT More 1 Year If Under 24 Hrs. Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months 219-16-8401 1 □ M 🔊 🗘 F Yrs. Mi. Non-1,1914 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he mouth once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 □ No m.D Funeral Director BAltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number D. S. A 1933 NorTheAST Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ BIACK 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Home to me maken th grade a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/227 20b. Place of Disposition (Name of cemetery, crematory or other place) LindA HALEThorse MD 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ARbutus ARBUTUS MD Aug. 17, 2007 21. Signature of Funera Fervice Licensee Betts Punekal BATO.MD, 212/3 23a. Parts. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician In Da. 100's Syndrome /Medical Examiner MEDICAL EXAMINER rain Stern Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disc to for as a consequence of Examiner Subdurd Henry to me CERTIFICATION APPICEDED Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes Dulmonary 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1□ Yes 2□No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient Certification: To 1 Yes -27 2 ER/Outpatient 3 DOA After this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 XNo Probable fall. within 24 hours as er dea h. To the Funeral Director: A completely filled in by the fu Accident
3 Suicide 07/15/07 Unknown 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1933 Northeast Ave 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide TICHE

Balto, MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year)

State Registrar

17

29b. Signature and title of certifier

31. Date filed (Mortin, Day, Year) OC 2 3 2007

MHD NAWRAS

NAWLAS 900 07 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Ave

08/12/07

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Care **Physician** Kenneth 12:05AM ()ctober 24,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore City Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 79 Months 1 TMM 2 TF Director 220-20-1195 27, 1928 West Virginia Usual Residence of Decedent 10c City Town or Location 10b County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Eximiner must be notified at 1 ☐ Yes 2 ☐ No Marvland Anne Arundel Glen Burnie Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 408 Arbor Drive 21061 United States by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2000 No If Yes, Give 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Ex-mine 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify White 3€Widowed 4□Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver **Transportation** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Cave Violet Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Carter / Sister 408 Arbor Drive Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct. 29, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cem. 2007 Pikesville, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home P.A.
421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Examiner Aortic Sequentially list conditions, have earning to mind and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed attending physician and I for use as the burial-transit Box 68760; Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 DEctopic pregnancy in the past 12 months? Month Day signed by the at d be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Division or Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed' 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation (Month, Day Year) Injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AT2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

M.D

32. Registrar's Signature

Jagadeesha

2007

31. Date filed (Month, Day, Year)

29

Union

Memorial Hospital, MD

			For State	State	of Maryl		artment of H rtificate of L		Mental Hy	giene Reg. No 2	07	34531
			Registrar  1. Decedent's Name (First, Middle	, Last)					2. Date of De	ath	Year	3. Time of Death
	Physicia	in		_	DUNNO	OV			Month Octobe	Day r 24	6:15pm <sup>M</sup>	
	/Medic		JACQUELIN  4a. Facility Name (If not institution			CV	4b. City, Town, or	Location of Death		4c. Cour	0.105	
	Examin	er				<b></b>	BALTI				N/A	
- 1			FUTURE CARE-  5. Social Security Number	6. Sex		yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Bit	th	9. Birthp	place (State or Foreign
	Funeral Director		218-46-8605	1 □ M 2 <b>XX</b>		62 Yrs.	Months Days	Hours Min.	JUNE 1		Cour	RYLAND
2	140	1	Usual Residence of Decedent			02			DON'S	1 1747	1.11.11	KILITIO
	land ow it	Ì	10a. State 10b. County		10c	. City, Town or L	ocation				1	10d. Inside City Limits
	Mary f sh ied a	ō	MARYLAND N/	Δ		RΔ	LTIMORE					1 X Yes 2 No
	the 28a-	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cour	ntry?
	with a or		455 MANSE C	rr.			212	0.1		11 0	6.A.	
	eath	Funeral	11. Marital Status		cedent Ever	in U.S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No		Race - Americ	
	iter d	ä	1)©Never Married 2 Marr	Armed F	Forces? 2 <b>X</b> No		_		o Rican, etc.)		Black, White,	
36	rs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, 0 Year or	Give Dates:		1 ☐ Yes 2 No	Specify:		Spe	cify: BLA	CK
ş	be filed within 72 hours after death with the Maryland tial Hyglene.  dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	P .		t's Education		16a. Dece	edent's Usual Occup	ation	-1-1	16b. Kind of	Business/In	idustry
15	in 72 n "na Aedis	Completed	(Specify only higher Elementary/Secondary (0-12)		(1-4or 5+)	life.	e kind of work done DO NOT use retired	auring most of wol d)	rking			
2	with iene tha	E	10th grade	College	(1-401 5+)		ISABLED			N/	'A	
ō	filed Hygi other ent, tl	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Nar	ne (First, Middle	e, Maiden Surr	iame)	
a	ld be enta ked ic ev	To B	HARRY N. DUNN	OCK				DOROT	HY MAE	WEEDON		
کّ	s 1 and 2 should be fi f Health and Mental Hitem 27 is marked of other traumatic evel		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mai	ing Address (Street	and Number or Ri	ural Route Numi	ber, City or Tox	vn, State, Zij	p Code)
Š	and 2 ealth a n 27 is		Denise Dunnock	/Daughtei	^	5302	Bowleys	In., Apt	G., Ba	lto., M	1d., 2	1206
ē,	tem tem othe		20a. Method of Disposition		2	0b. Place of Disp	osition (Name of ematory or other plac	ce)	Date	20c. Location	on - City or T	own, State
00	0 0		1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		m State		CEMETERY	1	30-07	LANSDO	WNE.	MARYLAND
Baltimore, Maryland 21215-0036	artme		21. Signature of Faneral Service				22. Name and Addre		NANATINI T (TISZ			
Ba	permit. Pag Department Important: I any injury o		1/2/		-		206 W NOR			FUNERA	IL HOM.	E P.A.
	T NEW		23a. Fart1. Enter the disease, or shock, or heart failure. List	r complications tha	t caused the					arrest,		Approximate Interval Between
	<b>D</b>		shock, or heart failure. List Immediate Cause (Final	only one cause or	n each line.		. Net	try D	Disea	d z		Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due	to (or as a co	nsequence of):	7 100	0009			-	
	Examiner				.0 (0, 00 0		•					
		e.	Sequentially list conditions, if any, leading to immediate	b. Due f	to (or as a co	nsequence of):						
	uted I	Examiner	Cause (Disease or injury	<b>S</b> .								
	exect anc	Xa	that initiated events resulting in death) Last	Due f	to (or as a co	nsequence of):		·				
8760	cate be executed oblysician and the burial-transit	dical F		d								
687	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	gi		u.								
Box	leath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		outcome pf p					23d.	Date of deliv	very
ă	leath atter	cial	in the past 12 months?		e birth 2 □ egnant at time		☐ Ectopic pregnanc ☐ Other (specify) _				Month	Day Year
P. O.	w requires that the debeen signed by the should be detached	ıysi	9 ☐ Unknown	9□Un	known							
ص	that led by deta		Part II. Other significant conditi	ons contributing to	death but no	ot resulting in the	underlying cause giv	ven in Part I.	23e. Did	tobacco use o	ontribute to	the cause of death?
qs	uires sign Id be	d by	cholang	io Ro	rcir	oma			10	]Yes 2□N	o 3□Pro	obably 4 🔀 Unknown
ö	v requ	Completed							24a. Wa	s an 2	4b. Were au	topsy findings available
ž	has has	μ							aut	opsy formed?	prior to c death?	completion of cause of
<u></u>	i; Th icate r, pag		^					00 Plant of Pa	1□ Yes		1 ∐Yes	2 No
Z.	sician; Th certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital:		0 T T T T T T T T T T T T T T T T T T T	Otl	har:	ath (Check only			-76.3
0	Phys this al dir	2	1 Yes 2 No		☐ Inpatient ate of Injury	2 ER/Outpati	BUL 3 DOA	4 KNUrsing	Home 5 ☐ Re	sidence 6 🗆 e how injury od		эпу)
Division or Vital Records,	Attending Physician; r death, ector; After this certifica by the funeral director, I	<u>0</u>	1 X Natural 5 ☐ Pendi	(A)	fonth, Day Ye		, Wo	irk? ]Yes 2 ☐ No				
Sic	ttend death stor: the	cat	3 Suicide 6 Could	not be	ace of injury -	At home, farm,	street, factory, office		28f. Location	(Street and N	umber or Ru	ıral Route Number,
$\leq$	or A after of Direction by	Certification:	4 ☐ Homicide determ	mined 200.716	illding, etc. (S	Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or T	own, State)		
_	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate hy completely filled in by the funeral director, page		29a, Certifier 1 Certify	ng Physician: To	the best of m	ny knowledae, de	ath occurred at the t	ime, date and plac	ce, and due to th	e cause(s) and	d manner as	stated.
	Hos 24 hc Fun etely	Medical	(Check only 2 Medica one)	I Examiner: On th	e basis of exa	amination and/or	investigation, in my	opinion, death occ	curred at the tim	e, date and pla	ice, and due	to the cause(s)
	Fo the within Fo the comple	Med	29b. Signature and title of certific	er			29c. Licen	se number		29d. Date si	gned (Month	h, Day, Year)
	⊢≯⊢ŏ			Phi	4514	AN	D 5	754	3	10-	25-	ゼフ
,	~		30. Name and address of person	n who completed a	ause of dooth	(Item 23a) /Tun	e Print)	, - /		, -		
1	, 1		P. SAWOHU	n wno completed c	1 94 1	INI R	ALTIMO	ORE CA	- BA	TIMI	RIS	mp 21222
-	C+	ate	31. Date filed (Month, Day, Year	3:	Registrar's	Signature		- 3/		, , , , , ,		
lba.	Regist		OCT 2 !	2007	le Avien	J. A	reser					m D 21 223
				47								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Fr Hospital: C872 10/20/07 TV Reg. No. 2 Date of Death Decedent's Name (First, Middle, Last) Year **Physician** 725 0 2007 aur s /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday **Funeral** 10 M 2□ F Jun 20, 1923 So. Carolina Director 251-26-5854 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a State 10b County r 28a-f show notified at 1 □XYes 2 □ No **Baltimore** Director Maryland N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ns 23a or 2 must be n U.S.A. 21216 1069 Ellicott Drive Funeral filed within 72 hours after death 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 11. Marital Status Black, White, etc. 1 ∏ Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married other than "natural", or Baltimore, Maryland 21215-0036 1943 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Calvert Distillery Elementary/Secondary (0-12) Skill Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If item 27 Is marked or Alice Davis Johnnie Davis injury or other traumatic ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1069 Ellicott Drive Baltimore, Maryland 21216 Birdie Davis Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 10/31/07 Owings Mills, Md 4 Dopation 5 Other (Specify) Garrison Forest Veterans Cemetery 22. Name and Address of Facility 21. Signature Funeral Sentce Licenses any i Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Paint Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): use as the burial-Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the aid be detached for 2 🗆 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe 2 □ No 2 🗗 ∏ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home The Nursing Home 1 Nursing Ho 3□ DOA 1 ☐ Yes 2 700 **XX**patient 2 ER/Outpatient Certification: To this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred filled in by the funeral 27. Manner of Death 28a. Date of Injury After (Month, Day Year) Iniury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death death 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name

2000

31. Date filed (Month, Day, Year)

2

9 2007

DHMH 17 Rev 1/2001

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			_ FUI	artment of Health and Mei rtificate of Death	ntal Hygie Reg.	2001 040	33
	Physici		Decedent's Name (First, Middle, Last)  Helen K. Ebbecka		Date of Death Month CODER 24,	Day 2007 Year 3. Time of 10:05	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  Westminister		4c. County of Death  Carroll	
	Funeral Director		Beverly Living Center  5. Social Security Number  6. Sex  1 M 2 R F  89 Yrs.	If Under 1 Year If Under 24 Hrs   o	Date of Birth (Month, Day, Ye Ctober 21,	0. Birthologo (State)	or Foreign
	Maryland 9-f ehow	tor	Usual Residence of Decedent  10a. State  Naryland  Carroll  10c. City, Town or L Finksburg	ocation		10d. Inside C 1 ☐ Yes	ity Limits
	h with the	Funeral Director	10e. Street and Number 2904 Carrollton Road P.O. Box 60	10f. Zip Code 21048		Citizen of What Country?	
036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other then *natural', or iteme 23a or 28e-f ehow event, I're Modical Examinal must be notified at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric  1 ☐ Yes 2 ☐ No Specify:	y Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
Maryland 21215-0036	vithin 72 ho ne. hen *natur e Medicel	Be Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation  kind of work done during most of working  DO NOT use retired)  Naker		b. Kind of Business/Industry	
2	should be filed within and Mental Hygiene. marked other then imatic event, Its M	e Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (F			
ylan	should be and Mental s marked o umatic eve	To B	George Konkus	Pauline	Tomcsa		
	ges 1 and 2 should it of Health and Men if item 27 is merke or other treumatic			ing Address (Street and Number or Rural R Box 620 Finksburg, Mary)			
altimore,	Pages 1: ment of He ant: If iten ury or oth		4 Donation 5 Other (Specify)	Russian Orthodox 10/29,	/07 Ba	c. Location - City or Town, State altimore Maryland	
Balt	permit. Page Department Important: If any njury or once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Sonard J. Ruck. Inc 305 Harriord Road Baltimo	ore Maryla	and 21214	
<b>\</b>	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause in each line.  Immediate Cause (Final disease or condition resulting in death)  a. — Due to (or a a consequence of):	ter the mode of tring, such as cardiac or reculous According	espiratory arrest,	Approxima Interval Be Opset and	tween
	Examiner	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	with Visca	lm D	hream 250	n
68760,	ficate be executed physician and s the burial-transit	edical Examine	that initiated events resulting in death) Last C Due to (or as a consequence of):				
_			IF FEMALE:				
P.O. Box	The law requires that the death centif te has been signed by the attending age 2 should be detached for use a	Physician/M		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day	Year
	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of 2 No 3 Probably 4	
Vital Records,		Completed			24a. Was an autopsy performed	24b. Were autopsy findings prior to completion of odeath? No 1 Yes 2 No	
Vita	sician: certific rector.	Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (		ee 6 Other (Specify)	
n of	ng P	on: To	1 Yes 2 No 10 In patient 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at Work? 28c	d. Describe how		
Division of	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No reet, factory, office 28f	f. Location (Stree City or Town, S	et and Number or Rural Route Num State)	mber,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal (Check only one)  1 Medical Examiner: On the basis of examination and/or in and manner stated.				s)
1	To t withi To tl	Ž	29b. Signature and title of certifier	29c. License number	29d.	Date igned (Month, Day, Year)	,
•	0		30. Name any Eddress of person who impleted cause of death (Item 23a) (Type	Print)	~	127/2007	N ,, ~
	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature	Porte Rd, Wi	J hun	SM MU-	1115]
I	Registr		por a grant Manager	locates.			

7-08226 Alfred

Mec

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 34534

Q. Galloway			State of	Maryland / De	partificate	of Death	2110 11101110		Reg. No.			
	Re	For State gistrar Decedent's Name (Firs	. Middle.Last)	4 11				2. Date of Month	Day	Year		ne of Death 516 hrs
ysician/ _xamine		Aifred	Q.	Gallou	Jay		i - antion of	Octob	er 22, 20	07 c. County of D		
	48	a. Facility Name (if not in		reet and number)		4b. City, Towr	n, or Location of			NA		
	L	Good Samaritan		7 Age (In.)	rs. last birthda					VDD/YYYY)	3. Birthplace oreign /	e (State or
Funeral		Social Security Number	6. Sex	2 F	42	Months Yrs.	Days Hours	Min. Oct.	11,15	965	Country)	Pary land
Director		2 - 98 - 8/35 sual Residence of Dece	edent 1		700						10d.	Inside City Limits
ану			County		City, Town or						1	Yes 2 No
Maryland 28a-f show any d at once.	5	mp N	IA	$\mathcal{L}$	altimo	10f. Zip Co	ode			itizen of Wha	t Country?	
Maryla 28a-f	Director	0e. Street and Number	- L'halle	Terrace		213	à		US			
th the 23a or notifi		(3.55 / 101 11. Marital Status	TIDEIL	<ol><li>Was Decedent Ever</li></ol>	in U.S.	Danadont	of Hispanic Orig	gin? ( Specify Yes , Puerto Rican, et	or No- c.)	14. Race - White,		ndian, Black,
ath wi	Funeral		2 Married	Armed Forces?	No		1	,		Specify: 6	Black	K
fter de	g F	3 Widowed		Yes, Give Year		1 Yes 2	No specify:	kind of work done	16b	. Kind of Bus		stry
hours afte "natural", Examiner	9			highest grade complet College (1-4 or 5+)	dı	iring most of worki	ng life. DO NOT	use retired)		hurch		
36 in 72 l han "	ompleted	Elementary/Seconda	y (0-12)	NIA	Mu	sician		r's Name (First N				
21215-0036 uld be filed within 7 Mental Hygiene, marked other than c event, the Medica	SI.	17. Father's Name (Firs	, Middle, Last)				Llovice	e Phillip	2C			
215 be file ental H urked vent, t	a		loway	no Print \	19b	Mailing Address	(Street and Nur	mber or Rural Ro	ute Number	, City or Tow	n, State, Zir	Code)
0 0 0 0	٦٩	19a. Informant's Name	Way - m	other	23	335 Mon	tibello_	<i>lerrace</i>	part	oc. Location -	IID	ווטוח
e, MD I and 2 sh Health an item 27 i	F	20a. Method of Dispos	tion	OTT JOIN	20b. Place of	Disposition (Name by or other place)	70 1	11-2-0	1			
nore ages 1 at of H t: If i	١	1 Burial 2 4 Donation 5	Other Specify:	Removal from State	King A	emorial	fark		4	01	2	IIID
Baltimore permit. Pages 1:8 Department of H Important: If it		21. Signature of Funer	a Service Licens	ee/		Name and	Narch	Fungra	Hon	in my	2/2	79
1750		Mary 1	1-11/h	ications that caused the	e death. Do no	it enter the mode of	f dying, such as	cardiac or respir	atory arrest	, shock, or he	art	Approximate Interval Between Onset and
ysician /Medical		failure. List only	one cause on ea	Methadone in								Death
Examiner		Immediate Cause (Fir or condition resulting	al disease a in death)	Due to (or as a consequent	uence of):							
	Sequentially list conditions,  b.  Support (or as a consequence of):											
	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated  Co.  Due to (or as a consequence of):  Co.  Due to (or as a consequence of):										
2 H .	Examiner	events resulting in de	ath) Last	Due to (or as a conseq	uence ot):							
0, be executed sician and hurial - transit	edical	X UNPENDED		#25\PFII,27	28a-f. 1	perME.g873.	11/20/07	7 TT				
OX 68760, sath certificate be exattending physiciar for use as the burial for use as the burial	Medi			23c. If yes, outcome	e of pregnancy			opic pregnancy		23d. Date Month	of delivery Da	ay Year
6876C certificate anding phys	ian/Me	23b. Was decedent properties past 12 months?	egnant in the	1 Live birth Pregnant at t		<ul><li>Fetal death</li><li>Other (Spe</li></ul>				1		
Box (e death or the attened for us	Physici	1 Yes 2 No	g Unknow					- Port I	23e. Did tob	pacco use cor	ntribute to t	he cause of death?
that the dened by the detached f				contributing to death	but not resulti	ng in the underlyin	g cause giveri ii	Traiti.	1 Yes	2 No	3 Prob	ably 4 🗸 Unknown
, P.O. ires that the signed by	) à	Cocain	e use						24a. Was a		. Were aut	opsy findings available ompletion of cause of
cords, law requir has been s	Completed								autops perform	med?	death? 1 ✔ Ye	- [ ]
Recc The lar cate ha							26.Place of De	eath (Check only				
tal Rec sian: The certificate ector, page	8		ed to medical	Hospital: 1 Inpatie	nt 2 🗸 ER	Outpatient 3	DOA Other	4 Nursing Ho	me 5	Residence		:
on of Vital Records, lending Physician: The law require eath. or: After this certificate has been si or: After this certificate, page 2 should b	1	1 Yes	No	28a. Date of Inju (Month, Day,Y	ry 28	o. Time of Injury	28c. Injury at V			now injury occ	curred	
on of nding Plant.  th.  r: After ne funera		1 Natural	5 Pending	End 10/23	2/2007 Fi	nd 2:04 pm	1 Yes 2		unk	Street and Nu	ımber or Rı	ıral Route Number, City
Division tal or Attendi	6	2 Accident 3 Suicide	Investigation 6 X Could no	ot be		, farm, street, facto	ory, office buildin		or Town S	State) rk Road		
Divising pital or At ours after d	1	Homicide	determin		other-s		the time, date an		1 11	o(a) and mai	nner as stat	ted.
			Certifying Phys Medical Examir	ner:On the basis of exa	ny knowledge, mination and/	or investigation, in	my opinion, dea	th occurred at the	e time, date			
To the To the To the	сошь	(Check only one) 2 29b. Signature and		and manner stated			29c. License nur	mber			signed <i>(Ma</i> r 23, 200	
	1	7.1		194	>		O.C.M.E			Octobe		
		30. Name and add	ess of person wi	no completed cause of	death (Item 23	a) 111 Penn Str	root Raltimo	ore MD 2120	1			
		Zabiullah A	li, M.D. As	sistant Medical E	xaminer	TITEIIITO						
	Sta			32. <b>Te</b> gistr	ar's Signature	Sports	0			OCME		
Reg	IFILE	reut (1	CTO Q	1111								

ORIGINAL

State of Maryland / Department of Health and Mental Hygier Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** HOLL 955 PM BERT fors 26 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BATTIMORO RALTIN ME FUTURE CARE IRVINGTON 8. Date of Birth (Month, Day, Year) NOV. 30 19 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** IXXM 2□ F 1915 SOUTH CAROLINA Director 91 215-07-9948 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County or 28e-f ahow in than "netural", or Itams 23a or 28e-f ahov the Medical Examiner must be notified at MYYes 2 □ No Director BALTIMORE N/A MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. APT 1001 501 DOLPHIN ST. ges 1 and 2 should be filed within 72 hours after death in the Health and Mental Hygiene.

If itam 27 is marked other than "netural", or Itams 23: or other traumatic event, the Medical Everther must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 Mo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2XNo Specify: Specify:BLACK 3X XVidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION CAB DRIVER/LABORER 3rd grade 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be unknown 2 TOM HOLLY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 W. Lexington St., Apt 10, Balto Md., 21229 Eleanor Ware/Grandaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. KING MEMORIAL PARK 11-02-07 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) Sign were of Fundal Service Lic 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death mmediate Cause (Final RECURRENT ASPIRATION PNEUMSWA Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** DIABETED MERLITUG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed SERZUNE Due to (or as a consequence of): Box 68760 INSUPPICIENCY Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown DENENTIA Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 5 Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No death. М 2 Accident Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To tha Vithin 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 27th 2001 ATTENDING 00056948 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATIMME NO 21217 300 ARAM) SULTE 34 TAMONDA PLAZE Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

OCT 2 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 03:12AM 2007 Houston Oct /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore, MD If Under 1 Year I If Under 24 Hrs. Medical 9. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year) 1 M 2□ F Months Days Hours Min. 220-68-2787 Usual Residence of Decedent Director 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Health and Mental Hygiene. To Is marked other than "natural", or Items 23a or 28a-f show then transitie event, the Medical Examiner must be notifiled at 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? 14. Race - American Indian Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) qur NIA permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, : 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Houston OUIS ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) m C Fadden -Rd Belto ind nthia pern 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 29/0 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Metro atonsville 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fluneral Service 270 22. Name and Address of Facility Approximate Interval Between Onset and Death 23a. Party Enter the disease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirtly, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Circhosis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hepatitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or s a consequence of) Examiner burial-tran and resulting in death) Last the death certificate be exec Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 ☐Ectopic pregnancy Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached it 1 ☐ Yes 2 ☐ No 9☐Unknown 9 ☐ Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe certificate 1☐ Yes 2 No or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) spital: 1 Inpatient 28a. Date of Injury 1 ☐ Yes 2 ER/Outpatient 3 DOA ٩ To the HospItal or Attending Ph within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Dath 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Division (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as season.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

Ketan State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

301

St. Paul

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Patel

2 9

B.

AM2556996M248

MD

Baltimore,

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death October thanie 8:26 PM **Physician** arris 22, 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, 4b. City, Town, or Location of Death give street and number) Examiner Baltimore Leeds NIA If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 219-70-1406 1 M 2 □ F Marylana Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show пs 23a or 28a-f shov must be notified at 1 Pes 2 No Baltimore Director mo NIA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 USA 7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Black Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Self-employed Elementary/Secondary (0-12) College (1-4or 5+) nter NIA permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other t any injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harris ames 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd. middle River, mD, 21220 wThorne Harris Sister Juanita 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ■Burial 2 □ Cremation 3 □ Removal from State Carmel Cen. Dundack, mé. 07 4 Donation 5 Dother (Specify) 270 Fredhilton Pass Baltimore, MD 21229 21. Signatur of Funeral Signatur Lioune Gory P. March Funeral Home P.A. 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Renal failure yeur /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-transit P.O. Box 68760, ₹ Due to (or as a consequence of): led by the attending physician detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown ardiomy op ath Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed 1 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

n

DHMH 17 Rev 1/2001

Registrar

N. Rullin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 107 Bulto Sulta 32. Registrar's Signature

m

21228

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 25,27,28a-f per me 8872 10/26/07dhb For State Registrar 34538 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Frank Hohman 15, August 2007 11:20 a<sup>M</sup> /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Months 1 XM 2 ☐ F 215-22-8786 82 Director 02/15/1925 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code South Decker Avenue 622 21224 U.S.A. · death \ Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ██No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: White δ 3 SWidowed 4 ☐ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n 27 is marked other than ".

It traumatic event \*\* Elementary/Secondary (0-12) College (1-4or 5+) Body and Fender Technician Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental August A. Hohman Louise Rothaupt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 stand 2 stand permit of Health an Important: If Item 27 is any injury or other trauonce. 622 South Decker Avenue Baltimore, Maryland 21224 August S. Hohman - (Son) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Holly Hill Mem Garden 08/18/2007 Middle River 1 
☐ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 21. Signature of Funer in Service Licensee 1407 Old Eastern Avenue Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part shoo, Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, if heart failure. List only one cause on each line. Immediat Cruse (Final disease or Indition **Physician** 1 week Pneumonia disease or windition resulting in death) In ba. nous /Medical Due to (or as a consequence of): A DA. TO DA. TO DESCRIPTION EXAMINER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of highly that initiated events Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical as the Box ( IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Por in the past 12 months? Month Day 5 ☐ Other (specify) P.O. I been signed by the a should be detached ☐Yes 2☐No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Dementia, Hypertension, Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Subdural Hematoma, Anemia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy page perform certificate 1 Yes 2 No Division or Vital Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 252 No 2 ER/Outpatient 3 DOA 1 npatient funeral 27. Manner of Death 28a. Date of Injury (Month. Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Attending i Militainnal 5 ☐ Pending investigation s after death.

I Director: A

od in by the fu 07/04/2007 Unknown <sup>M</sup> 1 ☐ Yes 2 X No Subject fell 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State 1300 S. Ellwood Ave. determined 4 Homicide ö Nursing Home Funerai L Baltimore, MD Hospital hours 29a. Certifier 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Ho within 24 h 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVENUE BALTIMOKE, -20D ASKIN 4940

Registrar

31. Date filed (Month, Day, Year)

OCT

2 6 2007

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October 25, 2007 9:37 P M **Physician** HOOS RICHARD HENRY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Frederick Memorial Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1**X** M 2□ 218-01-8254 89 10/23/1918 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County f show "natural", or items 23a or 28a-f shov dical Examiner must be notified at 1 ☐ Yes 2 No MD Frederick Frederick Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21704 USA 5955 Quinn Orchard Road by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 KMarried Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical end 2 should be filed within fealth and Mental Hygiene.
n 27 is marked other than "n ar traumatic event Elementary/Secondary (0-12) College (1-4or 5+) 4 Customer Contact Rep General Motors 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Hoos Mary A. Wipfield ၉ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any injury or other trauonce. Phyllis Tenney / Daughter 9648 Sandlight Court., Columbia, MD 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Augustine Cemetery 10/30/2007 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Cary L. Kaufman Funeral Home at MMP, 7250 Washington Blvd., Elkridge, MD 21. Signature of Funeral Service 21075 M01378 arty. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) endromyopat **Physician** /Medical Due to (or as a consequence of) **Examiner** distase LOVEDANY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and the burial-transit Physician/Medical Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending ph for use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Vear in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2☐ ER/Outpatient 3☐ DOA ၉ 1 ☐ Yes 2 ☐ 1 ☐ Yes 1 🔲 Inpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident neral Director: / filled in by the f 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0060417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johnson dr. Frederice Shah Thomas C Hemen 31. Date filed (Month, Day, Year) State OCT 2 9 2007 Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 7:15 AM M 10 23 2007 Marie Catherine Hagy 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center Bel Air, Maryland Harford Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 02/01/1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Min Hours 1 □ M 2 🛣 F Maryland 84 219-12-6064 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No MD Baltimore Kingsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 11813 Reynolds Road 21087 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Manufacturing Industry Factory Worker 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louisa Mohr Herman Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11813 Reynolds Road - Kingsville, Maryland 21087 Jane T. Hagy (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 10/29/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MECHANICAL DISSOCIATION ELGETRO Due to (or as a consequence of): PNEUMONIA LOBE FT LOWER Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) HYPORCHICAGINA HYPER OSMOLAR NONKETOTIC Dur to (or as a consequence of): SMALL BOWEL OBSTRUCTION 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an autopsy 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Inpatient 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 1 Yes 2 No

attending physician  $V_{\mathcal{C}}$  C मामिस्प्राप्त $\mathcal{C}$   $\mathcal{H}\mathcal{H}\mathcal{K}\mathcal{M}$   $\mathcal{M}\mathcal{C}\mathcal{C}$  Division or Vital Records, P.Ø. Box 68760 as the nse CAMERINE

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of the Funeral Director after distributed by the funeral director.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

ral", or items 23a or Examiner must be r

natural", or

event, the

traumetic

and ental Hygie

**Physician** /Medical

Examiner

Director

Funeral

۵

Completed

Be

ပ္

Examine

Physician/Medical

Completed

Be

P

Certification:

Medical

25.				rred	to	medic	a
	exan			1			
	10	Yes	21	No			

29b. Signature and title of certifier

5 ☐ Pending investigation 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

MD

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year) 26191 10/23/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

260 CATELNAY DAINE, SUITE 21/22B, BEL AIR, 19D 21014 ANUSKA SIRITHARA 31. Date filed (Month, Day, Year) OCI 2 \$ 2 \$2. Registrar's Signature

State Registrar

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 34541 State of Maryland / Department of Health and Mental Hygien [] [] [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Carolyn Heron Haschert **Physician** Oct 7:50 PM 2007 /Medical 4a. Facility Name (If not in stitution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HOWARD COUNTY GENERAL COLUMBIA MO. 5. Social Security Number 9. Birthplace (State or Foreign Country)

NARY LAND 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Daly, 1 M 2 F 84 Days Yrs. 312-20-057 Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No HOWARD ELLICOTT CITY by Funeral Director MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? PAYLSKIRK RUAD 3137 21042 U, S, A, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GEORGE HASCHERTUL MAY SOPER 2 LILLIAN 19a. Informant's Name/Relationship (Type, Print) HUSBAYN) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3137 PAULSKIRK ROAD RAYMOND F. HERON JL 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Date 10/29/07 ELLICOTT COTY MO. 4 ☐ Donatiop<sub>3</sub> 5 ☐ Other (Specify) TREST LAWN MEMORIAL 21. Signatur of uneral ervice Liceasee 22. Name and Address of Facility MARZYLLO FUNERAL CHAREL Þ 6009 HARFORD ROAD BALTIMORE. MO 31214 23a. Pant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dthar significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes 21 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

**Physician** /Medical Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Records, P.O. Box 68760, signed by the e Division of Vital or Attending Physician: ours after death.

neral Director: After this certific filled in by the funeral director. within 24 hours a To the Funeral 6 To the Hospital

**Funeral** 

Director

ir than "natural", or Iteme 23a or 28a-f ehow The Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after

of Health and Mental Hygis item 27 le marked other r other treumatic event,

ō <u>=</u>

5 permit. Page Department of Important: If eny Injury or once.

21215-0036

Baltimore, Maryland

Medical Certification: 1 Certifying Physician: To the best of my knowledge ideath occurred at the fine lide and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D54413 10/26/07 (3a) (Type, Print)
10840 Little Patuxent Pkny # 300 Colun

State Registrar

DHMH 17 Rev 1/2001

10

oung 31. Date filed (Month, Day, Year)

30. Imme and address of person who completed cause of death (Item 23a) (Type, Print)



**ORIGINAL** 

Item 8 per fb 8873, Ma/26/07 bb artment of Health and Mental Hygiene Amend Item 2 per fh, g873, 11/21/07 dentificate of Death 34542 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 1040 AM October 2007 /Medical 28 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Future Care Honewood 8. Date of Birt 3/14/19259. Birthplace (State or Foreign (Month, Day), Seath Country) If Under 1 Year | If Under 24 Hrs 5 Social Security Number 6 Sev last birthday) **Funeral** Hours 1 ☐ M 2 🗹 F 1920 SOUTH CAROLINA Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at Director 1 Yes 2 No MARYLAND 10e. Street and Number 10f. Zip Code 10g. Vitizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No ò 3XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) 6 THGRADE Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, th once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be IOHN ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ' Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Pacility 2140 N. Fulton Avenue 410 21217 iamo Joseph H. Brown Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 180frand /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to him surface cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed Jant DISCOL 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be irector, page 2 s autopsy performe Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Sectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 31464 10/29/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EUTAW St Soute 308 BALTIMORE 8Hm1 821 170 SHOALLS A N. 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10/25/2007 **Physician** Charles E. Jones, Sr. 3:30 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Howard Howard County General Hospital Columbia If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | 08/17/1939 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1**⊠** M 2 □ F Maryland 68 Director 220-36-2022 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h. County 1 ☐ Yes 2 No an "natural", or items 23a or 28a-f sh Medical Examiner must be notified Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 United States 7932 Roxbury Drive death v Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ulth and Mental Hygiene. 27 Is marked other than r traumatic event, the M Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 4 Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Anna M. Grace Mackelvy Jones ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 Is any Injury or other trau Mrs. Janice M. Jones (Wife) 7932 Roxbury Drive, Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Meadowridge Memorial 10/30/2007 Elkridge, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final END STAGE RENAC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has certificate has irector, page 2 2□No 1 ☐ Yes 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA 2 1 | Inpatient 2 ER/Outpatient 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 h (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification D64395 OCTOBER 26.2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10565 NEHARLIS ST, SUITE 209 BALTIMOTES, MO 21207 DANIEUE DOBERMAN MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** PAMELA JOHNSON 4:18 PM October 13 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5495 Cedar Lane Apt#909 Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 🗗 F 47 Jan. 10,1960 Texas 215-74-7322 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No **Funeral Director** Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5495 Cedar Lane Apt#909 21044 U.S.A. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Be Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Child Care Provider Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Lee Johnson Bonnie Pruiett 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Farquhar (stepfather) 9007 Parliament Drive Burke, VA 22015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State Metro Crematory 10-18-2007 Catonsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee 22 Name and Address of Facility Witzke Funeral Homes, Inc. MOIOSU 5555 Twin Knolls Road Columbia, MD 21045 23a. Part1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events and resulting in death) Last as a consequence of Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given, in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has birector, page 2 s autopsy 1∐ Yes 2 🛂 🕶 100 25. Was case referred to medical examiner? director, Home e of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours arren To the Funeral Direc 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and completed cause of death (Item 23a) (Type, Print) Columbia uss of person who completed cause of death (Item 23a) (Type, Print) Columbia, Md 21044 J. Elizabeth Dennis M.D. 10805 Hickory Ridge Rd. S Suite

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

ORIGINAL

32 Registrar's Signature

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** 200 /Medical 4c. County of Death wn. or Logation of Death not institution, give street and nur Examiner N/A Birthplace (State or Foreign Country) If Under 8. Date of Birth (Month, Day, Year) ial Security Number 6. Sex **Funeral** Months Days 1**½** M 2□ F Yrs. 02/21/1948 Maryland Director 59 216-50-2277 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show the notified at 10b. County 1 Yes 2 No Director N/A Baltimore Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a o USA 124 South Willard Street 21223 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 TYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 📉 No Specify: þ 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Environmental Management | Federal Government 12 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Charles Johnson, Sr Rosalyn Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important; if item 27 is any Injury or other trauonce. Stanley Johnson 3712 Downey Dale Dr, Randallstown, Md. 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify) 10/30/2007 Owings Mills, Md. Garrison Forest 21. Signature of Funeral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, 1300 Eutaw Place, Baltimore, Md. 23a. Part. Enter // e disease, or complice shock, or beart failure. List only on ter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition Khoun **Physician** disease or condition resulting in death) /Medical Examiner 10 M Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as a consequent Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes Ö 9 Unknown 9 ☐ Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pag 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Hknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autonsy nerform 2□ No 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 24 and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifie 2 (Item 23a) (Type, Print) Month, Day, State 9 2 2007

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#8, perFH G873 11/1/07 WS and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Year 0931 Hannah Ai-Nhi Jo October 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL Baltimore City Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days 19 1 M 200 Director 218-79-9453 Ortober 8, 2007 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes XXNo Director Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 765 Heather Stone Loop 21061 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No ģ Specify: Specify: Asian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Infant Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tam Tran 2 Beong Jo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tam Tran / Mother 765 Heather Stone Loop Glen Burnie, Md 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Oct. Date 29, 1 ☐ Buriat 2 XCremation 3 ☐ Removal from State Metro Crematory 2007 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): Congenital Heart Disease 19days disease or condition resulting in death) /Medical Examiner 9 day 5 Hype plashe Due to (of as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 700 24a. Was an was a... autopsy performed? Ves 2 No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident Iniury 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

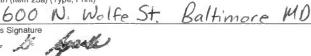
the Hospital or Attending Physiclan: within 24 hours a

> State Registrar

29b. Signature and title of certifier

McCrory Michael 31. Date filed (Month, Day, Year) 32 Registrar's Signature OCT 2 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

RES-000

29d. Date signed (Month, Day, Year)

October 27

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#2 per PHYS C872 10/29/07 WS State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 19 100 years 8:30 P **Physician** Ι Geneva Keene /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 11217 Arbutus Avenue Baltimore Bradshaw 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. Jully 25 1917 1 ☐ M 2 ☐ F Haywood, Virginia 217 28 9527 90 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Baltimore Bradshaw 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21087 USA 11217 Arbutus Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX ☐ No þ Specify: Specify: 3XXWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/Ă 6 Housewife Housekeeping-Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Melvin Ware Lucy Fletcher ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Rev. Andrew Keene 11217 Arbutus Avenue Bradshaw, Maryland 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Chapel Un. Meth. Ch. cem. 10/22/07 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EF Lassahn Funeral Home PA 11750 Belair Road Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medica! as the t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 menths? 1 ☐ Yes 2 Z No Day Year 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 2 10 Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my kr 29a. Certifier owledge, death eccurred at the time, date and place, and due to the cause(s) and manner as stated.

The property of the cause (s) and manner as stated.

The cause (s) and determine the cause (s) and due to the cause (s) and due to the cause (s) and due to the cause (s). 2 Medical Examiner: On the basis of examand manner stated. (Check only one) on and/g To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person wh

Akkad Year)

2007 4

Ayman Fathi 31. Date filed (Month, Day,

Division or Vital Records, P.O. Box 68760,

Towson, Md

completed cause of death (Item 23a) (Type, Print) 7600 Osler Dr.

07-08274 Stephen Kellner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Certif	icate of	Death	uiu iviei	пат пуд			000		
Physi	cia	1. Decedent's Name		•						Date of Dea		<del>201</del>	3. Time of D	eath 5
Medical Exa	min	occonen	Michae	el Kellner					0	Month October 2	Day 4, 2007	Year	1220 hi	s
		4a. Facility Name (if r Sinai Hospita		, give street and number)		4	b. City, Town,		of Death			nty of Deat	h	
Funera	a I	Social Security Nur		S. Sex 7. Age	- /1-		Baltimore							
Directo					(In yrs. last	birthday)	If Under 1 Y Months D	ear If Under ays Hours	er 24Hrs. 8. s Min.	Date of Bir	th(MM/DD/Y	YYY) 9. Bii Forei	rthplace (State	or
	4	212-96-1		1_XM 2_F	28	Yrs.	I I I I I I I I I I I I I I I I I I I	dys   Hours	S IVIII	05/08	/1979	Co	Mary	ไล่กด้
any		Usual Residence of D	Decedent Ob. County	<del></del>	10c. City, Tov	un or Locatio								
*	g ,	. MD	Bal	timore	Too. Oily, To								10d. Inside (	-
Aaryland 28a-f show	at once.	10e. Street and Numb		CIMOIC		OWI	ngs Mi						1 Yes	2 X No
he M	one ar one	12372 Gr	eenspr	ing Avenue			10f. Zip Code			10	Og. Citizen of		•	
hours after death with the Maryland Inatural", or items 23a or 28a-f she				12. Was Decedent B	Ever in LLC	142 14/00		1117					States	
death	Lingsto	1 X Never Married	2 Mari	ried Armed Forces?_		If Yes	Decedent of I s, specify Cub	dispanic Oriç an, Mexican	gin? ( Specify , Puerto Rica	/ Yes or No- in, etc.)		ace - Amer hite, etc.	ican Indian, Bl	ack,
after o	1	3 Midowood	4 Divor	1 Yes 2 2 ced If Yes, Give Year	X No		res 2 X N	lo specific				w W	hite	
ours	31 -		ation (Specif	y only highest grade comp	pleted) 16a	a. Decedent's	Usual Occur	ation (Give	kind of work	done	Special 16b. Kind of	·y.		
2 2 2	Completed	Elementary/Second	lary (0-12)	College (1-4 or 5-		during mos	t of working li	fe. DO NOT	use retired)	20110	TOD. TAILS OF	Dusillessi	iridustry	
003 within iene.		12				Te	acher/	Instru	ctor		Publ	ic Sci	hool Sy	zatom
filed Hyg				*						t, Middle, M	laiden Surna	me)	1001 5)	/scem
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than revent, the Medica	8	Joseph G.						Rh	onda I	Rosenz	weig			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 271s arraked other than rigiury or other trannatic event. It he Mental	12						ddress (Stre							
and 2 lealth tem 2		20a. Method of Dispos	ition	ner (Father)		12372	Greenst on (Name of c	oring	Avenue	, Owi	ngs Mi	ills,	MD. 21	117
Baltimore, permit, Pages I ar Department of Hee mportant: If ite				3 Removal from State	e crem	atory or othe	place)	emetery,	Dat	e	20c. Locatio	on - City or	Town, State	
Itim it. Pa rtmen rtmen		4) Donation 5	Other Spec	ify:	Drui		ge Ceme		10/30	/2007	Balti	more.	Maryl	and
Balti permit, Departm Imports	1	21 Sign re of Funer	al Service L	ensee		22. Nar	ne and Addres	ss of Facility					Inc.	and
Physician	$\vdash$	23a. Part Enter the d	isease or con	mplications that caused the	o doath Do	410	7 Wilk	ens A	venue,	Balt	imore.	Mary	land 2	1229
/Medical		. ,		odon inic.		not enter the	mode of dying	), such as ca	ardiac or resp	iratory arre	st, shock, or	heart	Approximate Between Or	Interval
Examiner	1	Immediate Cause (Fina or condition resulting in	al disease n death)	a. Methadone int	toxicati	on							Dear	
		Sequentially list condit	iono	b.	defice of):									
	ner	if any, leading to imme cause. Enter Underlyin	diate	Due to (or as a consequ	uence of):							_		
	Examiner	(Disease or injury that events resulting in dea	initiated	c. Due to (or as a consequ	uenco of):									
cuted nd ransit		events resulting in dea	in) Last	d.	derice or).									
760, icate be executed physician and the burial - transit	ledical	X UNPENDED		AMENDED 7 20			4 - 1	·						
tending Physician: The law requires that the death certificate be leath.  Tot: After this certificate has been signed by the attending physici. The funeral director, page 2 should be detached for use as the buris.	/Me	IF FEMALE:		#23a,27,28a 23c. If yes, outcome	of pregnancy	ME.g8/3	<u>, 11/2//</u>	<u>07 TT</u>			Tan-	-6 1 11		
68 certifi	_	23b. Was decedent prec past 12 months?	nant in the	1 Live birth		2 Fetal	death 3	Ectopic	pregnancy		23d. Date Month			ear
Box 68 e death certil	Physicia	1 Yes 2 No 9	Unknov	4 Pregnant at tin	ne of death	5 Other	(Specify)							
, P.O. Box 68 res that the death certif signed by the attending be detached for use as	P.	Part II. Other significat	nt conditions	contributing to death b	ut not recultir	a in the und	arly days acres	alores to Do		90 Billion				
P.O. es that the igned by	l by			same and the country	at not resulti	ig in the und	enying cause	given in Part	CI.				he cause of de	
cords, law requir has been s	Completed								— <u> </u>	4a. Was an			ably 4 🗸 Un	- 17
e law e has e 2 st	ם								'	autopsy	,	prior to co	opsy findings a empletion of ca	vailable use of
tal Recian: The		25 Was see			_		100-100		1	perform ✓ Yes 2		death? 1 ✓ Yes	2	No
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been si led in by the funeral director, page 2 should b	Be	25. Was case referred to examiner?		Hospital:	. [ ]				check only or	ne)				150
of V ng Phy Viter thi	-T	1 Yes 2 27. Manner of Death	No	inpatient	2 V ER/O				Nursing Hom		esidence 6	Other:		
on Con Con Con Con Con Con Con Con Con C	.E	1 Natural 5	Pending	28a. Date of Injury (Month, Day, Year)		Time of Injur		ry at Work?		Describe ho	w injury occu	rred		
iSic Atte er dez recto	ical	2 Accident	Investiga	FNd 10/24/				Yes 2 X N	u 1					
Div spital or ours afte reral Dir filled in	Certification:	3 Suicide 6 3	Could not determine	ين ما العد			ictory, office b	uilding, etc.	0	* Town. Star	te)		I Route Numb	
5 4 F S		20a Cartifier	ifving Physic		her-sce				1123	72 Gree	nspring	Ave. 0	wings Mi	11s, M
To the Hos within 24 h To the Fur completely	Medical	(Check only 1 Cert one) 2 V Med	ical Examine	rian: To the best of my kn r:On the basis of examina and manner stated.	iowieage, aea ation and/or ii	atn occurred nvestigation,	at the time, da in my opinion	ite and place , death occu	e, and due to irred at the tir	the cause(:	s) and manne	er as stated	i.	
5 3 5 8	₹	29b. Signature and title o	of certifier	and manner stated.			29c. License							
		7.1	- 1 1				O.C.1				9d. Date sig October 2		n, Day,Year)	
9	+	30. Name and address of	f person who	c impleted cause of death	(ltm 22a)						- Louer 2	J, 2007		
0'		Zabiullah Ali, M.		stant Medical Exam		I1 Penn S	treet, Balti	more. Mr	21201					
		31. Date filed (Month, Da	y, Year)	32. Fisgistrar's S	ignature	Some	- //		- 1201					
Regist	rar	00	292	907 Been	0 50.	17								
HMH 17 Rev 1/20 CME 2006	01				OR	IGINAL				OCME				

DHMH 17 Re OCME 2006

/Medical **Examiner** The law requires that the death certificate be executed as the burial-transi Division or Vital Records, P.O. Box 68760, attending physician ed by the attendin detached for use has been signed by ye 2 should be detacl this certificate within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral To the Hospital within 24 hours a To the Funeral L

**Physician** 

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

**Funeral** 

Director

State

Registrar DHMH 17 Rev 1/2001 MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LDPEZ

8415

MADULFO

Bellone Lam

MD

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 for use page 2 should certificate Hospital or Attending Physician: this funeral To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A filled in by the

For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Walter Kraska, 10:30 A M October 25, /Medical 2007 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death 1940 Searles Road Dundalk Baltimore Co. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 ☑ M 2 ☐ F 220-72-4768 3,1959 Alabama Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐Yes 2X☐No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1940 Searles Road 21222 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2[XNo 1 ☐ Yes 2 X No Specify White þ Specify. 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Forklift Operator Manufacturing 12 Vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter M. Kraska, Sr. Eleanor Acuri ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1940 Searles Road Dundalk, Maryland 21222 Eleanor Kraska (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Holly Hill Mem. Gdns. 10/29/2007 4 Donation 5 Dother (Specify) Middle River, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part. Enter the disease, amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (F disease or condition resulting in death) mediate Cause (Final Coronary Artery Disease 5 Years Due to (or as a consequence of) Atherosclerosis Sequentially list conditions, any sealing to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1<u>0 Years</u> Due to (or as a consequence of) Examiner Hypertension 20 Years Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes perform 1∐ Yes 2 No 2 🔲 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 X Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cortific 29c. License number 29d. Date signed (Month, Day, Year) D33407 October 26, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 207 Wise Ave. Deepak Seth, M.D. Dundalk, Maryland 21222 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2 9 2007 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene State Amend #10f&19b Per FH G8/2 10/29/01/29 Registrar 34551 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day KITT Month Year **Physician** BITH 10 03:55 A M 24 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A LEVINDALE HEBREW HOME If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 10/15/1914 Birthplace (State or Foreign Country)

VA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 214-10-0188 93 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show 1 Yes 2 No Director BALTIMORE N/A 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code <del>21208</del> 21209 6112 PIMLICO ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) other than College (1-4or 5+) BENNY'S BILLIARDS PROPRIETOR permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 1s marked othe any injury or other traumatic avent, 900cg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROSENHOFF **BREWER** BENJAMIN IDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6112 PIMLICO ROAD, BALTIMORE, MD 21208 21209 MICHELLE GOLDSTEIN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State HAR SINAI CONG. 10/26/2007 OWINGS MILLS, MD \* 4 □ Donation 5 □ Other (Specify) 21. Signature of uneral Service Licensee SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 lay of al Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or his riffailure. List only of e cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Immediat & Cause (Final disease of condition resulting in death) & LENRAL **Physician** FFFUSION /Medical Due to (or as a consequence of): **Examiner** MASSES 250 Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-tran-Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical as attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ĵ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? page certificate ! 2. No 1 Yes 2 No 1 ☐ Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 1 ☐ Yes 2 ☐ No 10 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After t 1 Nature.
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier PHYSICIAN 29c. License number 29d. Date signed (Month, Day, Year) BABATUNDE 10-24-2007 AJANI mis D0064533 3 CICRIFTRIC CTIZ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LCVIND TE - HEBREN 2434 BATTIMUNE MA 21215 W. BEVILDERE BASATUNDE AJAN 1 Ave. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State made OCT 2 9 2007 Registrar

			For State Registrar	State of	Maryland / D		ent of H		nd Men		ene 0 0 .	7 345	52
	200		1. Decedent's Name (First, Middle,	Last)						Date of Death Month		3. Time	of Death
	Physicia /Medic		Jeanette T	. Leishur	e					ctober	,	007 9:30	AM M
	Examin		4a. Facility Name (If not institution,	give street and numb	oer)	4b. (	City, Town, or	Location of	Death		4c. County of	Death	
			FutureCare Cl	nerrywood				ersto				imore	
1	Funeral	200	5. Social Security Number	6. Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs. last birth	Mon	nder 1 Year ths Days	If Under 2 Hours	Min. 8. C	Date of Birth Month, Day,	Year)	<ol> <li>Birthplace (State Country)</li> </ol>	or Foreign
3.	Director		220-05-9136	1 L M 2 X	88 <sup>Y</sup>	rs.				ec. 2,		MD	
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						10d. Inside	City Limits
	aryla shov	-	Toa. State		Too. Only, Town	0. 20041011							s 2 V No
	Be-f	ctc		imore			sville	2					
	it t	Director	10e. Street and Number			101	, Zip Code			110	g. Citizen of Wh	-	
	23a		303 Maiden Ch				212				USA		
	r de	Funeral	11. Marital Status	12. Was Deced Armed Forc	es?	13. Was D If Yes,	ecedent of H specify Cuba	ispanic Orig in, Mexican,	in? (Specify , Puerto Rica	Yes or No- in, etc.)		American Indian, White, etc.	
36	72 hours after death with the Maryland naturel', or Iteme 23a or 28e-f show otsal Exeminer must be notified at	by Fi	1 Never Married 2 Marrie	If Yes, Give		1 □ Ye	es 2X No	Specify:			Specify:	***	
8	72 hours natural',	d D	3 ₩idowed 4 Divorced	Year or Date		Danadontio	Usual Occup	ation			16b. Kind of Busi	White	
21215-0036		Completed	15. Decedent' (Specify only highest	grade completed)	10a.	(Give kind o	of work done of OT use retired	during most	of working	, '	TOD. KING OF DUST	noos moosny	
12	d within giene. r than	E	Elementary/Secondary (0-12)	College (1-4	tor 5+)			7			Hoschil	d Vohn	
	D 00 5		12 17. Father's Name (First, Middle, L	ast)		Sa1	es	18. Mother	r's Name (Fil	rst, Middle, N	faiden Surname)		
ano	b a la b	Be							Darbas	es Vin	~		
Ë	should ind Men marke umatic	유	Homer E. Turne:  19a. Informant's Name/Relationsh		19h	Mailing Add	trass (Street			ra Kin	City or Town, SI	tate. Zip Code)	
Maryland	tra Tra					NAMES COLD							
	1 and 1 deal and 2 liner		Samuel Leishure 20a. Method of Disposition	2	20b. Place of	Disposition	(Name of		Date	ister	stown N	<ul> <li>1D 21136</li> <li>ity or Town, State</li> </ul>	
ō	0 0 = =		1 ☐ Burial 21 Cremation	3 Removal from St	ate		or other plac	!			196		
ţ	ermit. Pag epertment nportent: I ny injury c		4 Donation 5 Other (Sp		, Carrol		mation ne and Addres		10/24		Hampsto		
Baltimore,	Depe mpo mpo nny ir		21. Signature of Fureral Service L	Sons of 1 A	111111	9.00						stown Ro	
3	40280	Н	unun	100000	non		ie Fune					MD 2113 Approxim	
			23a. Part1. Enter the disease, or shock, or heart failure. List of	only one cause on each	ch line.					*		Interval B	letween
A.	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a	(sul)	Mul	Vacu	eller	Lec	edent		300	eus
15	/Medical Examiner		rosaming in dodny	Due to (o	r as a consequence o	of):							
		<u></u>	Sequentially list conditions, if any, leading to immediate	b	as a consequence o	10							
I	ed isit	Examiner	cause. Enter Underlying Cause (Disease or injury	000.00	. 45 4 555545555								
J	death certificate be executed e attending physician and of for use as the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (o	r as a consequence of	of):				_			
60,	be ea ician buria	calE			•								
68760,	physicate physicate			d									
×	ding se as	/Me	IF FEMALE:	23c. If yes, outco	ome of pregnancy						23d. Date	of delivery	
Вох	death certifica attending ph d for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th 2 Fetal death		oic pregnancy or (specify)	′			Mont		Year
	by the de	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknov		2 🗆 Опте	ii (specily)						
P.0	The law requires thet the site has been signed by the bage 2 should be detache		Part II. Other significant condition	ns contributing to dea	ath but not resulting in	the underly	ing cause giv	en in Part I.		23e. Did tob	acco use contrib	oute to the cause of	of death?
Records,	uires l signe	d b	D	enertes						1 🗌 Ye	is 2.₽No 3	B Probably 4	Unknown
Ö	v requ	Completed	(	<						Ode Mhe e	a Josh W	aro autonou findini	ae available
ec	e taw has b	ldu	<u> </u>	enjeries						24a. Was an autops perform	v pri	ere autopsy finding for to completion of ath?	cause of
F		S		7								∃Yes 2□No	
Vital	sician: T certificet rector, pa	Be	25. Was case referred to medical examiner?	Hospital:			T DOA Oth	000		heck only on			
of	Physician: this certific ral director,	10	1 Yes 2 No	1In	patient 2 ER/Out		J DOA	4 Nu			once 6 Other	· · · · · · · · · · · · · · · · · · ·	
n n	ding F h. After funera	Certification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending		Day Year)	ime of njury M	28c. Injur Wor			. Describe no	w injury occurre	u .	
Division	ten leat lor: the	cat	2 Accident investig	ot be	1111 - 1111			Yes 2 1		Location (St	mot and Number	r or Rural Route N	um haz
$\leq$	l or Attendate death Director:	E	4 Homicide determi	200. Place C	of Injury - At home, fai g, etc. (Specify)	rm, street, ta	aciory, onice		201.	City or Towr		0/112/2/1102/014	uniber,
	urs a			- Di		d						nos os stated	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the t Examiner: On the bas	sis of examination and	d/or investig	ation, in my o	me, date an pinion, dea	u piace, and Ih occurred a	at the time, d	ate and place, ar	nd due to the caus	e(s)
	thin the mple	Med	29b. Signature and title of certifier	and manne	o, stated.		29c. Licens	se number		2	9d. Date signed	(Month, Day, Year	-)
	8 4 8	-	290. Signature and time of the	mo					4				
			1	, ,	1.		170	, ,			- 1		
	4		30. Name and address of person	who completed cause	death (Item 23a) (	Type, Print)	,	620	(	Com man	o To	4107 re Rd	7 12 4
	32. 3		31. Date filed (Month, Day, Year)	32.	gistrar's Signature	nun	(	010	3	~,0		7-4	- ing
	Sta Registi	ate rar	OCT 2 9	2007	e. H	Lucas	6,						
DI	MH 17 Rev 1/2		00123	2001	A COM	7							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 0 0 7 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1632M LEE ERVIN Critoba 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, JUNE 9 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1XOXM 2□ F Yrs. Director 247-32-7085 84 1923 SOUTH CAROLINA Usual Residence of Decedent death with the Manyland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show treumatic event, the Modical Examiner must be notified at XXYes 2 ☐ No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2604 GUILFORD AVENUE 21218 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 22 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. should be filed within 72 hours after and Mental Hygiene.

marked other than "naturel", or ite 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: þ 3X XWidowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BALTO CITY SANITATION WORKER 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t and 2 should be fill Health and Mental H tem 27 is marked ott Be LAURA MEEKS ပ ROBERT LEE MEEKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a the street or other tree 4312 Plainfield Ave., Balto. Md., 21206 Mildred Meeks/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ' 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 11-01-07 BALTIMORE, MARYLAND KING MEMORIAL PARK 21. Signature of preral Servicensee 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Jer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine-diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. rever principar; Atter this certificate has been signed by the filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 Z No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of/certifier 2 October 25, 2007 30. Name and address of per on who completed cause of death (Item 23a) (Type, Print) Webb Union Mumoria currina Buchman 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2007

OCT 2. 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene

Amend Item 18 per FH 9873 11/14/07dhb

Reg. No. 2 0 0 7 2. Date of Death 1. Decedent's Name (First, Middle, Last, 2007 October 26, **Physician** Dorothy McKean 8:45 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1307 Scottsdale Drive Apt. Harford Bel Air If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 20, 15 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 X Director 84 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State a or 28a-f show the notified at 10b. County 1 □Yes 2 X No Director Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1307 Scottsdale Drive Unit C 21015 LISA "natural", or items 23a Examiner must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married white Maryland 21215-0036 1 ☐ Yes 2 X No Specify 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygis Important; If item 27 is marked other any injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (*Eirst, Middle, Maiden Surname*) Be William James Keenan Myrtle ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Tillinghast (Daughter) 804 S. Fountain Green Road, Bel Air, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriat 2 X Cremation 3 ☐ Removal from State 10/27/2007 Hilltop Svc. Corp. Towson, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funer Service Licensee 1050 York Road, Towson, Maryland 21204 rant. Enter the discrete recomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, edited condition.

Fibrosis Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical r as a consequence of) Due to 6 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran and Due to (or as a consequence of) Box 68760. been signed by the attending physician should be detached for use as the buria þ Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No page 2 this certificate 1□ Yes To the Hospital or Attending Physician: within 24 hours offer death.

To the Funeral Director Affer this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 🔀 Naturai 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO completed duse of death (Item 23a) (Type, Print) 30. Name and address of person loans 21093 Falls 1075 #225 Day, Year) 32 Registrar's Signature 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a i Department of Health and Mental Hygiene 23a Certificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 7 1313 **Physician** Myrtle A. Myers 5003 /Medical 4b. Cify, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SINAT HOSPITAL OF BALTITURE Baltmore City 8. Date of Birth (Month, Day, Year) July 7, 19 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Months Hours Min. Days 1□M 2X F 84 Yrs. Canada 1923 217-20-9491 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2X No Baltimore Pikesville Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code and 2 should be filed within 72 hours after death with latth and Mental Hyglene.

7.7 is marked other than "natural", or items 23a or ry? is marked other than "natural", or items 23a or er traumatic event, the Medical Examinar must be a pratural or traumatic event, the Medical Examinar must be a 21208 United States 515 Marshall Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Maryland 21215-0036 Specify: 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public school Cafeteria worker unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel V. Wood Alfred Tryon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4719 Water Tank Road Manchester, Md. 21102 Charles P. Myers, Jr. - son permit. Pages 1 and Department of Health Important: If item 27 any injury or other tra Baltimore, Oct. B, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Hampstead, Maryland 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremation 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Eline Funeral Home 934 South Main Street Hampstead, Maryland 21074 M01072 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SepHC VED BY MEDICAL EXAMINER Shick **Physician** /Medical Due to (or as a consequence of): Examiner Fascillys Necicution Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran CERTIFICATIO Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>}</u> 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 1□ Yes 2 No page 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes <del>2⊡√lo</del> 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Unknown<sup>M</sup> 5 ☐ Pending investigation **☑** Natural 1 ☐ Yes 2 📉 No Subject fell. 10/02/2007 124 hours after death.

Be Funeral Director: A sletely filled in by the funeral properties. 2 XAccident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 515 Marshall Ave. 3 ☐ Suicide 4 ☐ Homicide Medical 29a. Certifier (Check only one) To th. within 2. To the Fu and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Ockber, 7, 2007 RFS-060 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Belvedere Give, Balkmore, Mi)
HAMED MIRNAIS, M.D. Singly Hespital of Balkmore 18 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCT 09

-2007

ないこと

State of Maryland / Department of Health and Mental Hygiene 20 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3.50 PM OCTOBER Johannah Morse 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT RALTIMORE AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** 1□M 2 F Months Days Hours Director 480-24-6879 86 08/25/1921 Iowa Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits items 23a or 28a-f show iner must be notified at 1 ☐ Yes 2 No MD Baltimore Catonsville Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 Lee Drive 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Pheobe Throubaugh 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 82 Virginia Lane, Glen Burnie, Maryland 21061 ce of Disposition (Name of Date 20c. Location - City or Town, State Mrs. Jean Mullins (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 10/31/2007 Glen Burnie, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee . 9 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ASPIRATION PNEUMONIA 2 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YEARS ALZHEIMER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → No 24a. Was an autopsy performed? Yes 2 No 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) E Vishne Deepike 20998 OCTOBER, 26, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. CATON AVE., BALTIMORE, MD - 21229 900 VISHNU DEEPIKA EVURI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 202486 Registrar 9 2007

DHMH 17 Rev 1/2001

JOHANNA

MORSE

Division or Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a-f per men 872,10/23/07dhb 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month September **Physician** John 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore Bayriew Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Days **Funeral** Hours Months 1XM 2□ F 218-14-8090 81 Maryland July 11, 1926 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show at 1 ☐ Yes 2 ☐ XIo be notified Director Baltimore Dundalk Maryland 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number ö USA 21222 'natural", or items 23a 63 Vista Mobile Drive Examiner must Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 Ϊ No Maryland 21215-0036 þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) within 72 Elementary/Secondary (0-12) College (1-4or 5+) Construction Bricklayer 10 years 12 should be filed war and Mental Hygier 18 marked other th 18. Mother's Name (First, Middle, Maiden Surname) or other traumatic event, 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: if Item 27 is marked any injury or other traumatic ev Evelyn Eckels John Meyers ပ 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23 Bon Bon Court, Reisterstown, Maryland 21136 Daughter Lynn Hart Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Moreland Memorial 20c. Location - City or Town, State September 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parkville, Maryland 26, 2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Home Of Dundalk, P.A. 21. Signature of Funeral Service Licens 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death for on 11935 Immediate Cause (Final 11000 **Physician** disease or condition resulting in death) /Medical FOR DA. Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed CERTIFICATION Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day in the past 12 months? I□Yes 2□No ed by the 9 ☐ Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1□ Yes Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nres <del>2 No</del> 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 27. Manner of Death After Injury a 1 Tolyanural 5 Pending investigation Unknown M 1 ☐ Yes 2 ☐ No 09/20/2007 probable fall. 2X Accident nours after death. death. 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 63 Vieta Mohile 6 ☐ Could not be 3 ☐ Suicide City or Town, State) 63 Vista Mobile Drive, Dundalk, MD determined 4 ☐ Homicide n 24 hours a 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hos within 24 ho To the Funcampletely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 21, 2007 RES-000

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

OCT 2

4940 Eastern

Avenue Beltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

M.O.

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 34558 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Frances T. Miante 10-15-2007 2:25 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2707 Riva Rd. Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Director 030-09-4050 93 07-04-1914 Usual Residence of Decedent 10c. City, Town or Location Items 23a or 28a-f show 10a. State 10b. County 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2707 Riva Rd. 21401 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 🛣 No ģ Specify: White 3X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ns any Injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) GT&E Sylvania Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peter Milone Mary Minervini 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Tower Drive, Stevensville, MD 21666 Gerald Miante/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Michaels Cemetery 10/20/2007 4 □ Donation 5 □ Other (Specify) Boston/MA 22. Name and Address of Facility
Cary L. Kaufman Funeral Home at MMP, 21. Signature of Funeral Service License 7250 Washington Blvd., Elkridge, MD 21075 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VECT Cerebrovexu /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 month Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 100 1□ Yes 25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Death 28b. Time of 28d. Describe how injury occurred Certification: atural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 🔲 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit Division or Vital Records, P.O. Box 68760.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

Medical

STEPITEN

29b. Signature and title of ceptifier

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31 RUBINSON ROAD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 🖳 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

MAJZ, MD 31. Date filed (Month, Day, Year)

and manner stated

DCT 2 9 2007



**Physician** /Medical **Examiner** or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician this After after death. within 24 hours a To the Funeral L

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

28a-f show

ō

23a

items ;

0

"natural"

Hygiene.

the Medical Examiner must be notified

use as the burial-trar Certification: To filled in by the funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier D66152

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) mb 22 3. Greene Street Rm N5W68, Baltimare mb 21201 31. Date filed (Month, Day, Year)

State Registrar



			For State Registrar	State of	Maryland / De	epartment of Certificate			ental Hy	giene Reg. No	2007	34560
	Physici	an	1. Decedent's Name (First, Middle, Las	st)					2. Date of De Month October	Day	5, 20°07	3. Time of Death 2:45 P M
	/Medi Examir	al	Helen E. Neubert  4a. Facility Name (If not institution, give	e street and numb	ner)	4b. City, Tox	wn, or Location		oc tobel		County of Death	
	Examin	ier	Gilchrist Center			Towsor					altimore	
2	Funeral Director		212-09-5136	ex	Age (In yrs. last birthe	Months D	fear If Under lays Hours	Min.	8. Date of Bird (Month, Da 4/29/19	916	Cot	place (State or Foreign intry) 'land
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  MD  Baltimon  10e. Street and Number  200 Purlington Ro  11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  (Specify only highest grave)  Elementary/Secondary (0-12)  8  17. Father's Name (First, Middle, Last, Joseph Wagner  19a. Informant's Name/Relationship (Gloria A. Neubert)  20a. Method of Disposition  1 Burial 2 Cremation 3 Chemical Authority (Specify Potter)	Dad  12. Was Deced Armed Force 1   Yes 2 1   Yes, Give Year or Date ducation College (1-4)  Type. Print)  Type. Print)  Removal from Si	19b. Marter 200. Place of Example care.		t of Hispanic O Cuban, Mexica No Specify Cocupation done during mo etired)  18. Moth Ann treet and Numb treet and Numb of or place)	nst of workin mer's Name na Sur ma Suraber or Rural ad	g (First, Middle MME'S Route Numb MOnium	16b. Ki Ov , Maiden er, City o	or Town, State, Z Yland 2 ocation - City or	ican Indian, ,, etc.  te Industry  Ip Code) 11093
Baltir	permit. F Departme Importar any injur		21. Signature of Funeral Service Licer	nsee	>	22. Name and A	Address of Faci	neral	Towso	on, N	Maryland	
38760,	Physician /Medical Examiner  sthe purial-transit	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <u>069</u> Due to (o Due to (o	r as a consequence of	in .	My					Onset and Death weeks
Box 6	requires that the death certifica een signed by the affending ph nould be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ②No 9 □ Unknown	1 ☐ Live bir	ome pf pregnancy th 2 □ Fetal death nt at time of death vn	3 ☐ Ectopic preg 5 ☐ Other (spec					23d. Date of deli Month	ivery Day Year
rds, P.O	iw requires that to be been signed by should be detailed.	d by Ph	Part II. Other significant conditions	contributing to dea	ath but not resulting in t	ne underlying cau	se given in Part	t I.			in.	the cause of death?
al Records,	The law ate has b page 2 sh	Completed by						·	24a. Was auto perfi 1 Yes		prior to death?	topsy findings availabl completion of cause of 2□ No
Vital	Physiclan: r this certific ral director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	patient 2 ☐ ER/Outp	atient 3 DOA	Othor:		(Check only		e Bother (Spe	city) hospic
Ö	ding Phys 1. After this funeral di	ion: To	27. Manner of Death 1 Death	28a. Date of (Month			. Injury at Work? 1 ☐ Yes 2 [	2	28d. Describe			city) respice
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filed in by the funeral director,	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place o	of injury - At home, fam g, etc. (Specify)	n, street, factory, o			28f. Location ( City or To	Street ar	nd Number or Ru	ıral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (	(Check only 2 Medical Exa	hysician: To the t miner: On the ba and manne	poest of my knowledge, sis of examination and er stated.	or investigation, in	n my opinion, d	eath occurr	and due to the ed at the time	, date an	d place, and due	e to the cause(s)
	within To t	Σ	29b. Signature and title of certifier				S & 3				tte signed (Mont	
	H		30. Name and address of person who			ype, Print)	0	C4-	720-1	200	Mp 2	(2014
	St	ate	31. Date filed (Month, Day, Year)		gistrar's Signature	N. CA	pelles	<i>- ۲</i>	, 000		, -	7

DHMH 17 Rev 1/2001

			For State Registrar		State of Ma	aryland			nt of He te of D		d Men		2 0	07	34561
	Physici	an		(First, Middle, Last		GEI	UF	(	211/6	ENS		Date of Death	Day	Year	3. Time of Death
	/Medic Examin		ROBE 4a. Facility Name (#		street and number)					ocation of D	eath	x 24		nty of Death	12:38 PM
	Funeral Director		5. Social Security N 215-32-54			e (In yrs. las		B <sub>R</sub> If Unde	r 1 Year	If Under 24 H		Date of Birth	<b>193</b> 5	9. Birth	place (State or Foreign intry) SC
	land w		Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Loc	cation							10d. Inside City Limits
	ith the Marylan or 28e-1 ehow	tor	MD						Balt:	imore					1 Yes 2 □ No
	ath with the 23a or 28	al Dire	3578 Dud1					10f. Zi	p Code 2:	1213		10	g. Citizen	of What Cou USA	intry?
21215-0036	after des or iteme	by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ed 2 Married 4 Divorced	12. Was Decedent Armed Forces? 1 MYes 2 1 If Yes, Give Year or Dates:		1f		edent of His ecify Cuban	panic Origin? , Mexican, Pr Specify:	? (Specify uerto Rica	Yes or No- n, etc.)	8	Race - Amer Black, White rican Ar	
5-0	naturei',	letec	(Ѕрес	15. Decedent's Edi	ucation le completed)		16a. Deced (Give )	ent's Usu	al Occupat onk done du	tion uring most of	working	1	6b. Kind o	f Business/li	ndustry
2121	within liene. r then	Completed	Elementary/Second	ndary (0-12)	College (1-4or 5	i+)	iire. L		ailor			N	lichols	son Clea	aners
	2 should be filed withir and Mental Hygiene. ie marked other then aumatic event, the Ms	To Be C	17. Father's Name (		es Owens, Sr			1		18. Mother's		st, Middle, M ie Owens		name)	
Maryland	nd 2 shou eith and M 27 ie mar ir traumat		19a. Informant's Na Catherine	E. Goode	ype, Print) Sister	1	19b. Mailin	a Addres 578 D	s (Street a	Avenue;	Rural Ro Baltir	ute Number, nore, Ma	City or To	wn, State, Zi 1 2121	ip Code)
Baltimore,	82=5			osition Cremation 3 [] 5 [] Other (Specify)		cer	ce of Dispos metery, crem ison Fo	natory or	other place	em. 10/	Date /31 /200			on · City or 1	own, State  Maryland
Balti	permit. Pa Departmer importent any injury once.		21. Signature of Fu	neral Service Licens	Jones	$\supset$	22.	. Name a	nd Address	of Facility	Wylie	Funeral	. Home,	P.A.	
68760,	Physician but still but st	edicai Examiner	23a. Part1. Enter the shock, or heal Immediate Cause (disease or condition resulting in death)  Sequentially list conditions are greatly as a greatl	nd failure. List only of Final nditions, modified rithing injury	b. Due to (or as Due to (or as Due to (or as d.	a conseque	eal	2	_	such as car	diac or res	spiratory arre	st,		Approximate Interval Between Onset and Death
.O. Box	death certif e ettending d for use a	by Physiclan/Me	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal o	leath 3	Ectopic p	pregnancy specify)				23d.	Date of delin	v <b>ery</b> Day Year
rds, P	law requires that the de es been signed by the c 2 should be detached f		Part II. Other signif	icant conditions co	intributing to death b	ut not result	ling in the un	nderlying	cause give	n in Part I.				contribute to	the cause of death?
I Records,	The ete h	Completed										24a. Was ar autopsy perform 1 Yes 2	ed?	prior to death?	topsy findings available completion of cause of
Vital	ysicien: The I is certificete he director, page	Be	25. Was case refer examiner?		Hospital:				Othe			neck only one	•		
ō	Attending Physicien: r death. sctor: After this certificator, by the funeral director.	n: To	1 Yes 2 27. Manner of Deat	h	1 ☐ Inpation	irv 2	R/Outpatient 8b. Time of		28c. Injury Work	4 34 1401511		5 Reside			ufy)
sior	death. ctor: Aft y the fun	catio	1 Natural 2 Accident	5 Pending investigation 6 Could not be		y rear)	Injury	М		es 2 No					
Division	itei or Att rs after d rei Direct led in by	Certification:	3 Suicide 4 Homicide	determined	building, et	c. (Specify)	ne, farm, stre					City or Town	State)		ral Route Number,
	To the Hospitei or Attend within 24 hours after death To the Funerei Director: completely filled in by the	Medical	29a. Certifier (Check only one)	2 Medical Exam	vsician: To the best iner: On the basis o and manner st	f examination	ledge, death on and/or inv	estigatio	n, in my op	inion, death o	place, and occurred a	t the time, da	te and pla	ce, and due	to the cause(s)
	To Toon	2	29b. Signature and	title of certifier				1	oc. License	-		29	d. Date sig	gned (Month	n. Day, Year)
Λ	H		30. Name and addr	ress of person who a	completed cause of o	death (Item :	23a) (Type. i	Print)	V20	508 NGRO	NG.	SH	000	7 24	, 00 /
1	/ *		3900 L	OCH A	PAVEN	BLU	0	BAL	TIM	ORE	, ~	200	121	S	
	Sta Registi		31. Date filed (Mon	A.S.	32 Angistr	ar's Signatu	re &	and .	3						

OWENS, ROBERT EUGENE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34562 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** -15 A M POORBAUGH 28 MARGARET KEMP 7005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Long Green Nursing Home Baltimore 8. Date of Birth (Month, Day, Year) 10-6-1928 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🔀 F Months Days Hours Min. 79 Director 220-20-2627 PA Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits la or 28a-f show t be notified at MD Baltimore Towson Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 may Injury or other traumatic event, the Medical Examiner must be n once. 84068 Charles Valley Court 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Secretary Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Donald Margaret Fraser 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Poorbaugh, Sr./Hus. 8406B Charles Valley Court, Towson, MD 21204 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Dulaney Valley Memorial 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 11-01-2007 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License 1050 York Road, Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a CEREBRO VASCULAR Physician ACCIDENT disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** HEMORRHAGE INTRA CEREBRAL cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 22 No certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Oct 29 2007 D0053150 5 grupte

State Registrar 9650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ShakuNMALA

OCT 2 9 2007

31. Date filed (Month, Day, Year)

GUPTA M.D

32. Registrar's Signature

Suite 110

1021045

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 14:28 PM October ennie 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examine Johns Hopkins Bayview Medical Baltimore Cit-Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2X F 415-50-3676 March 10,1931 Tennessee Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 X Yes 2 ☐ No N/A Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 **USA** 1315 South Clinton Street Apt 210 by Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 2 should be filed within 72 hours after cand Mental Hygiene. is marked other than "natural", or iter raumatic event, the Medical Examiner 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sewing Factory Worker 11 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fi Health and Mental ! Grace Hembree Clabe Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trat once. 1014 South Elwood Avenue, Baltimore, Maryland 21224 Mary Griffin sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Stanislaus 20c. Location - City or Town, State October 20a. Method of Disposition 30, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 2007 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Point enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to has a consequence of): hours Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | Probably 4 Nuknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a Was an autopsy performed? Yes 2 No certificate ha 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဂ္ this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 X Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Meliul Doctor Res - 000

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns Hopkins Beyvin Medical ( Year) 32 Registrar's Signature

Boritz

31. Date filed (Month, Day, Year)

OCT 2 9 2007

21224

Center, 4940 Eastern Avenue, Baltimore, Maryland

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State of Marylar State of Marylar Registrar	Cer	tificate of L	eaith and iv Death	ientai Hyg F	Reg. No. 2 (	007	34564
	Physicia	an	Decedent's Name (First, Middle, Last)		<del>-</del>		2. Date of Dea	Day	Year	3. Time of Death
	/Medic	al	Virginia Parkman		41-00-7		Octobe	126,	2007	11:30AM
	Examin	er	4a. Facility Name (If not institution, give street and number)  Doctor's Community Hospital		4b. City, Town, or Lanham	Location of Death			y of Death ce Geor	raes
,	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	h		ice (State or Foreign
	Director		220-12-2604 1□M 2束F 81	Yrs.	Months Days	Hours Min.	(Month, Day April 2	3,1926	Maryla	ind
9	W It		Usual Residence of Decedent           10a. State         10b. County         10c. Ci	ity, Town or Loc	cation				10	d. Inside City Limits
N.	a-f sh	ţŏ	Maryland Prince Georges Law	urel						1 ☐ Yes 2 🙀 No
4	or 28	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Countr	y?
Ť.	s 23a		8615 Locust Grove Drive		20707			USA		
) †	item iner n	Funeral	11. Marital Status  12. Was Decedent Ever in L Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☑ No	J.S.   13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ice - America ack, White, e	
	ral", or	by	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	1	☐ Yes 2☑ No	Specify:		Speci	″ <sub>fy:</sub> Whi	te
לי היי	he med within 7 £ mods area death with the way hat tall Highene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at event,	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupa kind of work done di OO NOT use retired)	tion uring most of work	ing	16b. Kind of E		,
7	than the Me	dmo	Elementary/Secondary (0-12) College (1-4or 5+)		O NOT use retired)	_			s Hopk	sics Lab
א ק	Hygi other ent, tl	Be Co	17. Father's Name (First, Middle, Last)	Clerk		18. Mother's Name	e (First, Middle,			STCS Lan
Subsuid to filed within 70 hours after death with the Mandand	snough by more with and Market land Market of the land aumatic event, the Market land aumatic event, the Market land land land land land land land land	To B	Thomas William Elliot			Elizabet	h Field	ding		
	is me		19a. Informant's Name/Relationship (Type. Print)		g Address (Street a					Code)
, <b>c</b> , <del>c</del>	Health em 27 ther t	-	Richard Parkman- son  20a. Method of Disposition 20b.	Place of Dispos	Locust Gr		e, Laure	20c. Location		un Chata
2000	ages ent of it: If It y or o		↑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cren	natory or other place	10/30/2			-	
		1	21. Signature of Funeral Service Licensee	22	Cemetery  Name and Address	s of Facility		Crownsvil		- T
ב ב	8 2 2 8	10	Mugh moizzy	7	leck Fune 601 Sandy	ral Home Spring	INC. Rd., La	urel, M	1D 2070	)7
			23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	th. Do not ente	er the mode of dying	, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	e cur	Liomyo	pattry				ondot and boats
	xaminer		Due to (or as a consec	HPMSIC	int	. I				
<b>-</b>	, ±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	quence of):	)	1				
ofico	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consec	Mic.	peop	ratory	MSCH	iconc	1	
ficate he executed	physician and sthe burlal-transit		Due to (or as a consec	quence on.	,	)	(		1	
i de de	g phy as the	edical	d							
3 4	atte ding p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fet		Ectopic pregnancy				ate of deliver	
9	by the at	/sici	in the past 12 months?  1		Other (specify)			M	lonth [	oay Year
that t	igned by be detac		Part II. Other significant conditions contributing to death but not res	sulting in the un	derlying cause give	n in Part I.	23e. Did to	bacco use cor	ntribute to the	cause of death?
The law requires that the death of	n sign	ed by	Urinum moct infe	ehun			1 □ Y	′es 2□ No	3 ☐ Proba	bly 4 Unknown
o we	as been si 2 should	plete	provincia				24a. Was a		. Were autop:	sy findings available
		Completed	Atrial Zibrilaha	on, C	eogulos	Within	autop perfor 1 Yes	rmed?	death?	pletion of cause of □ No
alclan	certificate rector, pag	Be	25. Was case referred to medical examiner?		Cult	26. Place of Deatl				
2 4	h. After this funeral dir	은	27. Manner of Death 28a. Date of Injury	ER/Outpatient 28b. Time of	28c. Injury	4 ☐ Nursing Ho	me 5 Resid			
	ath. or: Afte	atior	1 Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		? ′es 2 ☐ No		,,		
TATE OF THE	ter de Ilrecto n by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At h building, etc. (Speci	nome, farm, stre	et, factory, office	-=10.00	28f. Location (S City or Tow	Street and Num	ber or Rural	Route Number,
֓֞֞֜֞֓֓֞֜֓֓֓֓֓֓֓֓֓֓֓֓֟֓֓֓֓֓֓֓֓֓֓֓֓֓֓֟֓֓֓֓֓֓֓֡֓֡֓֓֓֓֡֓֓֓֡֓֡֓֡֡֓֡	eral C		29a. Certifier 18 Certifying Physician: To the best of my kn	owladge death	Occurred at the time	o data and place	and due to the			
the Hospital or Attending Physician:	within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	edical	(Check only one) 2 Medical Examiner: On the basis of examin and manner stated.	ation and/or inv	estigation, in my op	e, date and place, inion, death occur	red at the time,	date and place	, and due to	the cause(s)
To	To the	Me	29b. Signatule and title of certifier		29c. License			29d. Date sign	ed (Month, D	ay, Year)
	_		D1717		H80	60925		10/2	4/07	,
1	7		30. Name and address of person who completed cause of death (Item  LUZABTH FASCA  31. Date filed (Month, Day, Year)  OCT 2 9 2007	m 23a) (Type, F	Print)					
$\perp U$	r I		ELIZABAH FASIKA 5	75 M	AIN SIKE	81 501	18 331	LAUR	El, Al	0 20107
	Stat	te	31. Date filed (Month, Day, Year)  OCT 2 9 2017  32. Registrar's Sign	ature						

			For Amend State Registrar	Item 2	State of <b>per</b> of	Maryland lr.,g87	d / Depa 2 <b>,10/2</b>	rtment of H	lealth and N Death		L	07	34565
	Physicia	an	1. Decedent's Name (Firs	st, Middle, Last)						2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Charles  4a. Facility Name (If not in	institution dive	Paig			4h City Town o	Location of Death	Sept. 2		ty of Death	2000 M
	Examin	er	Clinton Nu				er	Clinton					eorges
	Funeral Director		5. Social Security Numbe 172–14–0048	6. Se		7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 08–14–	Year)	9. Birthp Cour A1:	place (State or Foreign htry) abama
	faryland show ed at	or		edent County rince G	eorges		,TownorLo					1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the N 28a-i notifi	Director	10e. Street and Number					10f. Zip Code			0g. Citizen o	of What Cour	ntry?
	h with	al Di	7420 Marlbo	oro Pik	e			2074	7		U. S.	Α.	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ □		12. Was Deced Armed For 1  Yes If Yes, Give Year or Da	ces? 2.[∑XNo e		Was Decedent of H f Yes, specify Cuba I ☐ Yes    ※☐ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. R B	ace - Americ lack, White, cify: B1.	
2	72 hour		15. [	Decedent's Edu	ıcation		16a. Deced	dent's Usual Occup	ation during most of wor	kina	16b. Kind of	Business/In	dustry
1717	d within 7 giene. Ir than "r the Med	Completed	Elementary/Secondary 6th		College (1-	4or 5+)		kind of work done DO NOT use retired al Clerk	(d)	9	U. S.	Post	al Service
2	ld be filed ental Hyy ked othe ic event,	To Be C	17. Father's Name ( <i>First</i> , unknown	, Middle, Last)						ne <i>(First, Middle,</i> ed Paige		ame)	
a	2 shou and M is mar aumat	-	19a. Informant's Name/F	Relationship (7)	/pe. Print)			ng Address (Street High Gro		ural Route Numbe White Pl			
ב ט	1 and Health tem 27 other tr	7	William Pa: 20a. Method of Disposition				lace of Dispo	sition (Name of		Date	20c. Locatio		
5	Pages tment of tant: if it tury or o		1 ☑ Burial 2 ☐ Cre 4 ☐ Donation 5 ☐	Other (Specify,	)	state i	t. Oliv	vet Cemet	ery	6/2007		ngton	, DC
Dal	permit Depar Impor any In		21. Signature of Funeral	1 0	Bacon	1. CC3		. H. Baco					on, DC 2001
	Physician /Medical Examiner		23a. Part1. Enter the di shock, or heart fail Immediate Cause (Final disease or condition resulting in death)	lure. List only o	DO COLLEG OR OF	ach line						-	Approximate Interval Between Onset and Death
,0070	icate be executed physician and sthe burial-transit	edical Examiner	Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ons, liate gy	cDue to (	or as a conseq or as a conseq	uence on:  work of the second	anteny !	91.		3		
O. DOX 00	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 □ Yes 2 □ No 9 □ Unknown	gnant iths?		irth 2 ☐ Feta ant at time of c	aldeath 3∐	□Ectopic pregnanc □ Other (specify) _	у		I	Date of delive Month	very Day Year
cords, r	quires that n signed b	b	Part II. Other significan	et conditions co	_	eath but not res	ulting in the u	nderlying cause giv	ven in Part I.				the cause of death?
T T	: The law recate has bee page 2 shot	Completed								24a. Was autop perfo 1 Yes	rmed?	prior to o death?	topsy findings available ompletion of cause of
VITAL	sician certifi rector	Be	25. Was case referred t examiner?	to medical	Hospital:		150/0 1	Oti	oor.	ath Check onl		0.1. (0.	
on or	ling Phys After this funeral di	ion: To	2.5	Pending	28a. Date (Mont		28b. Time of Injury	of 28c. Inju	4 ls Nursing I	dome 5 Residence			ify)
DIVISION	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident 3 Suicide 6 4 Homicide	investigation Could not be determined	28e. Place	of injury - At h ng, etc. <i>(Sp</i> eci	ome, farm, st	reet, factory, office		28f. Location (	Street and Nu vn, State)	ımber or Ru	ral Route Number,
	e Hospita 24 hours e Funeral letely filler	Medical C	29a. Certifier 1 (Check only one)	Certifying Ph	niner: On the b	best of my kno asis of examina ner stated.	owledge, dear ation and/or in	th occurred at the to	ime, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) and date and pla	d manner as ce, and due	stated. to the cause(s)
1	To th within To th	Me	29b. Signature and title	of certifier		0	<i>(</i> 22) •	29c. Licen D256	se number 40		29d. Date si		n, Day, Year) 2007
,			30. Name and address Khosrow Da			e of death (Iter	m 23a) (Type,	Print) anch Ave	., Clin	ton, Md.			
	Sta Regist	ate rar	31. Date filed (Month, D	2 9 200	7	legistrar's Sign	ature	ule					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				1 - State Amend Item Registrar	25 per me,	,g872,	10/23/	<b>And the</b> of	Death		Reg. No 20	07	34566
		Physicia	an	1. Decedent's Name (First, Middle		-1				2. Date of Do Month		Year	3. Time of Death 0125 M
0		/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	or Location of Death		4c. Count	y of Death	0125
		LAGIIIII	C1	Baltimuse VA	medical cen	I .		Battan			N/		
		Funeral Director		5. Social Security Number  213-20-4721  Usual Residence of Decedent	6. Sex 1 <b>X</b> M 2 ☐ F		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year)	Coun	lace (State or Foreign htry) Ltimore
	yland	at		10a. State 10b. County		10c. City	y, Town or Lo	cation	·			1	0d. Inside City Limits
	e Mar	Ba-f sh tiffied	Director	MD		E	Baltin						1 XYes 2 No
	ath with th	ns 23a or 28a-f show must be notified at		10e. Street and Number 348 S. Sma					223			ted S	States
	Maryland 21215-0036  d 2 should be filed within 72 hours after death with the Maryland	"natural", or Items edical Examiner m	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Marr  3 ☑ Widowed 4 □ Divorced	If Yes Give	<sub>⊒No</sub> ww ai	nd rea	1 □ Yes 2 X No		pecity Yes or N o Rican, etc.)	Speci	ice - America ack, White, of ify: Whi	etc. . te
ì	ן-לר ח-לר ח	"natu edical	Completed	(Specify only highe	it's Education st grade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of worked)	king	16b. Kind of E	Jusiness/Inc	dustry
3	Z1Z d withi	giene. sr than "r the Med	) mo	Elementary/Secondary (0-12)	College (1-4o	or 5+)		olice O			Balt	imore	city
-	ind 2 be filed	th and Mental Hygir 7 is marked other traumatic event, ti	Be	17. Father's Name (First, Middle, Mack Mc					18. Mother's Nam	ne <i>(First, Middle</i> n Youl	e, Maiden Surna	me)	
•	aryla should	and Mental I is marked or aumatic eve	욘	19a. Informant's Name/Relations	<b>_</b>		19b. Mailii	ng Address (Street	t and Number or Ru		ber, City or Towr	n, State, Zip	Code)
:	, Ma	Health ar		Sandra L. Bo		hter	348	S. Sma	llwood F	Road	Baltimo	ore,	MD 21223
	<b>Saltimore,</b> permit. Pages 1 al			20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 ☐Removal from Sta			osition (Name of matory or other pla		Date	20c. Location	•	
:		Department of Important: If i any Injury or once.		4 □ Donation 5 □ Other (5		Lal		W Mem.Go  2. Name and Addre	ds. 09/1	2/07	Sykes	ville	e, MD
1	Balt permit.	Impo any once		Wholet ?	2000		18	Hubbar	d Funera				21220
				23a. Part1. Enter the disease of shock, or heart failure.	r coordications that caus only one cause on each	sed the deat	h. Do not en	ter the mode of dyi	ing, such as cardiac	or respiratory	arrest,	HOIE,	Approxima e Interval Between Onset and Death
	J	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Into Due to (or a	as a conseq	bleecl uence of):	(subdur	nl and in	tonventrie	ular bleed	()	3 bays
	E	xaminer	_	Sequentially list conditions if any, leading to immediate	b						111	1)	
-	nted	unsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	as a conseq	uence oi):		_ /	0 1	M EXAMINER		
	<b>68760,</b> tificate be executed	physician and the burial-transit	Еха	resulting in death) Last	Due to (or	as a conseq	uence of):		$\Lambda \Lambda$	O BY ME	KCALL		
į	<b>68760,</b> fficate be ex	physici the bu	Medical		d				TEL MOY AS	ABA -			
ا لا	VISION OF VITAI RECORDS, P.O. BOX 6 Attending Physician: The law requires that the death certifi	විසි	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknowr	n 2 ☐ Feta tattime of d	I death 3[	⊒Ectopic pregnand □ Other (specify) _	OSMIR LINOVA		23d. D	ate of delive	ery Day Year
	S that	gned b	y Pr	Part II. Other significant conditi						_	tobacco use co	ntribute to th	he cause of death?
ed.		s been signed t	ted I	h/o PE, DVT	multiple N	•	. '	, ,	ppetipldemi	1	Yes 2 🔼 No		bably 4 ☐Unknown
axe	VITAL RECOLDS, Iclan: The law requires the	cate has b	Completed	LOPD,		hah	Men	ism		per	is an 24b copsy formed? 2 No	prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
	VIT:	s certificate lirector, pag	o Be	25. Was case referred to medica examiner?  1 Pyes Pyes Ne	Hospital: 1 Ninpa	atient 2 🗆	ER/Outnatie	nt 3 DOA Ot	26. Place of Dea		<i>rone)</i> sidence 6 □0	ther (Specia	
	DIVISION OF	After this funeral di	<b>-</b>	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date of I		28b. Time o				e how injury occi		
	Sio	tor A the fu	Certification:		igation	inium - At h	amo farm et	M 1 [	]Yes 2□No	29f Location	(Stroot and Num	nhar or Pur	al Route Number,
1		ater c I Direct d in by	ertifi	4 ☐ Homicide determ	nined building,	etc. (Specii	y)	reet, factory, office			own, State)	iber or mare	ai Moute Number,
	e Hospita	within 24 hours are deafth.  To the Funeral Director A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  1 Certifying 2 Medical	ng Physician: To the be I Examiner: On the basis and manner	s of examina	owledge, deat ation and/or in	th occurred at the to	time, date and place opinion, death occu	e, and due to thurred at the time	ne cause(s) and i e, date and place	nanner as s e, and due t	stated. to the cause(s)
	Toth	To the comp	Me	29b. Signature and title of certifie					se number		29d. Date sign	ned (Month,	Day, Year)
				Media	w Sill	ee!	41)		59198		9/1	-10-	7
(	At			30. Name and address of person					et, Balti	more M	D 2120		
\		Sta		31. Date filed (Month, Day, Year,	32. Regi	istrar's Signa		2 0	,				
	1.54	Registr	ar	OOT 20	N7 MA	M	Borne						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ricko WILLIAM October 25, 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner DAIT DUNDALK MORC MANOR If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F 78 216-24-3800 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show d 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene. It amd Mental Hygiene. ?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MATYLAND DUNDALK 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16.5.A 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1. Dyes 2 □ No If Yes, Give Year or Dates: Army 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retized) Bethlehen Elementary/Secondary (0-12) College (1-4or 5+) PHINTER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) OFA 600019 ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau BAltreere, 4100 MARIAN ElAINE 10/be NICCO 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cenetery Oct 30,2007 BA HIMORE MARYLOWD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Polity Joseph N. ZANNINO Jr. Funeral Hack Joseph N. ZANNING 263 3. Coulding Street are PAltimore, HDZ1224 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. is only one cause on each line. Immediate Cause (Final tickardio vascu **Physician** teriosc disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1☐ Yes 2 No page 2 s Hospital or Attending Physician: 24 hours after death.

e Funeral Director: After this certifical letely filled in by the funeral director. 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 Residence 6 □Other (Specify) P 4 Nursing Home 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical Within 24 ho

To the Functional and manner stated. To the 29c. License number 29b. Signature and title of certifier 866 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hill CT. Lutherville 0119 6 Trim 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend state of Mary Rand / 196p anthent of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** ZZ:35 M bessie October 25 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Hopkins Hospital CITY Johns | Da / T / More | T / T | Under 1 / Y | E / T | T | Under 1 / Y | E / T | T | E / T | T | E / T | T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | E / T | Birthplace (State or Foreign Country) 6. Sev 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2**X** F 219-62-1943 Usual Residence of Decedent Director 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. To Be Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN MEMAKER 12HIGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should Department of Health and Men 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 i 4LONZO NBURNIE MD 21061 Important: If item 27 any Injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State CEME 11-01-07 CROWNSVILLE, MA 4 ☐ Donation 5 ☐ Other (Specify) IR. FUNERAL HOME 21. Signature of Funeral Service Licensee TO. MD, 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final actic ac. dosis 48 hours **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 150 Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed burial-transit Due to (or as a consequence of). and attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy for in the past 12 months? Month Day Year 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) P.0. the signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Division or Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been a 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? Yes 2 X No 10 rector, 25. Was case referred to medical 26. Place of Death Check onl one Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 To the Hospital or Attending Phys within 24 hours after death,

To the Funeral Director; After this of completely filled in by the funeral directors. 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Medical Obetor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Santosh 600 North Wolfe Dommen 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 9 2007 Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

9

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #7, perFH, C872, 10/30/07 TT Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 28, 3:45 a Joseph Harold Sams October 2007 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Middle River Baltimore Earls Road If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 XM 2 ☐ F 91 01/04/1916 Ohio 283-05-0940 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 No <u>Middle River</u> Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21220 U.S.A. 516 Earls Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 TYPES 2 No 1943-If Yes, Give Year or Dates: 1945 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify: White 3 ☐₩idowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Salesman Wholesale Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ralph Sams Fern Oakley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Montrose, California 91020 Barbara Ruth Harrison- daughter 2425 Florencita Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem Gard. 11/01/2007 Middle River, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 21. Signature of Fur era. Signature Lit ensee 1407 Old Fastern Avenue Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediat Cause (Final disease r condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 2□ No

Physician /Medical Examiner

Physician

**YMedical** 

**Examiner** 

**Funeral** 

Director

or 28a-f show e notified at

ral", or items 23a or Examiner must be r

'natural",

al Hygiene.

uth and Mental Hygiver 27 Is marked other retraumatic event, til

Health em 27 I

permit. Pages 1 Department of H Important: If ite any Injury or ot once.

the Medical

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Box 68760.

O

Division or Vital Records, P.

Directo

Funeral

þ

Completed

Be

ပ

the Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-trans certificate After I Director: A completely filled in by

Examine Physician/Medical þ Completed Be Certification: To Medical

29a. Certifier

25. Was case referred to medical examiner? 27 Manner of Death

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 DUnknown

1 Tes

1 X Natural

2 Accident 3 Suicide

4 Homicide

	24a. was autoj perfo 1 Yes		prior to condeath?	
26. Place of Death (0	Check only o	one)		
Other: 4 Nursing Home	5D Hesi	dence 6	6 □Other (Spec	ify)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

investigation		M	1 ☐ Yes	2 No	
Could not be determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)
/					
Certifying Physi- Redical Examine	cian: To the best of my known: On the basis of examina	owledge, death occurre	ed at the time, da	ate and place n, death occu	e, and due to the cause(s) and manner as stated.  urred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

29c. License number

29d. Date signed (Month, Day, Year)

on who completed cause of death (Item 23a) (Type, Print) 515 Fairmount Ave. Towson, MD 21286

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28a. Date of Injury (Month, Day Year)

Registrar DHMH 17 Rev 1/2001

State

within 24 hours a To the Funeral I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 28, 2007 6:05 Swoboda Albert Ам Paul /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Gilchrist Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 1,1926 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours XIM 2□F 81 MAryland Director 219-14-1241 Usual Residence of Decedent 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ral", or items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 197 Victory Lane 21014 USA Completed by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 🛣 No Specify. 3X Widowed 4 ☐ Divorced Year or Dates: other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 years Self Employed Upholstering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Thomas Swoboda Gladiola Magdalene Garrison ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Whitley Daughter 197 Victory Lane, Bel Air, Maryland 21014 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State October 29. permit. Pages
Department of Important: If it
any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory Baltimore City, MD. 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Licensee Sonnelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part1. Enter the disease, or complications that caused the death. onot enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STROKE **Physician** Mouth disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown igned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation s after death 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 ☐ Homicide determined To the Hospital c within 24 hours af To the Funeral D 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 2 9

faulkner ma 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

555W.

Registrar

1 ouscutou

	1	For State Registrar	State of Marylar		artment of Hortificate of L				007	3457
Physician		. Decedent's Name (First, Middle, Last)	MILDRED P	). SI	HIPLEY		2. Date of De Month OCT.	Day	200 <sup>Year</sup>	3. Time of Death 9:50 A M
/Medical Examiner	4	a. Facility Name (If not institution, give str	N VILLAGE	to a brieff day	4b. City, Town, or  WESTMI  If Under 1 Year			4c. Co	CARROL	
Funeral Director	2	Social Security Number 6. Sex 214-03-7337	7. Age (In yrs	91 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 8 / 6 / 1	916	Cou	ntry) RYLAND
filed within 72 hours after death with the Maryland Hygiene. Hygiene. Wher than "natural", or items 23a or 28a-f show pm, the Medical Examiner must be notified at a Completed by Filmeral Director	1	0a. State 10b. Counfy MD CARROLL		ity, Town or Lo	ISTER			100 Citize	n of What Cou	10d. Inside City Limits 1 ☐ Yes 2 X No
s 23a or 2 rust be no		10e. Street and Number 531 SULLIVAN RI	. 2. Was Decedent Ever in I	12 12 1	10f. Zip Code 2115		ecity Ves or N	US		
urs after death v Examiner must by Funeral	2	11. Marital Status  1 □ Never Married 2 □ Married  3 ※ Widowed 4 □ Divorced	2. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	Rican, etc.)		Black, White	
be filed within 72 hours after death with riat Hygiene. d other than "natural", or items 23a or event, the Medical Examiner must be Re Commileted by Firmeral Di	najaidiii	15. Decedent's Educi (Specify only highest grade) Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	Give	dent's Usual Occupa kind of work done of DO NOT use retired SEAMS	luring most of work )	ing		of Business/lu	
e de la	ם כ	17. Father's Name (First, Middle, Last)	ILTON	POWE	ELL	18. Mother's Nam	e (First, Middle LUCY		urname) KEMPEI	₹
s 1 and 2 should be if Health and Menta item 27 is marked other traumatic ev	1	19a. Informant's Name/Relationship (Type RICHARD E. WARD)	ENFELT -SO	N 531	ng Address (Street a	N RD.,	WESTM]	NSTE	R, MD	21157
00-		20a. Method of Disposition  1 ☑ Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	EVE	RGREEN	osition (Name of matory or other place  MEM.GA	RDENS	26/07	FINK	SBURG	, MD
permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service License 23a. Part. Enter the disease, or complice		25	54 E. MA	IN ST.,	WEST	INST		
Physician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Pneumoni  Due to (or as a conse	a	ter the mode of dyn	g, such as carate	o, roophatory			Approximate Interval Between Onset and Death
Examiner	uer	Sequentially list conditions, if any, leading to immediate cause. E.ite. Underlying Cause (Disease or injury	Alzheime Due to (or as a conse		ementia					
cate be executed oblysician and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
ath certification attending properties	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	□Ectopic pregnanc	/		23	3d. Date of deli Month	ivery Day Year
w requires that the dibeen signed by the should be detached	2	Part II. Other significant conditions con	tributing to death but not r	esulting in the I	underlying cause giv	en in Part I.				the cause of death?
The law rec	Completed						24a. Wa aut per 1∐ Yes	opsy formed3	prior to death?	itopsy findings availa completion of cause o 2 ☐ No
certifi ector	lo Be	25. Was case referred to medical examiner? 1 \( \text{Yes} \) 2 \( \text{No} \)	lospital: 1	☐ ER/Outpatie	III 3 DOA	26. Place of Dea			□Other (Spe	cify)
To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dil	Certification:	27. Manner of Death  1 ☑ Natural  2 ☐ Accident  3 ☐ Suicide 4 ☐ Homicide	28a. Date of Injury (Month, Day Year, 28e. Place of injury - Al building, etc. (Spe	t home, farm, s	M 1	ry at rk?  Yes 2 ∐No			l Number or Ri	ural Route Number,
Hospital or 24 hours after Funeral Die stely filled in	Medical Cert	One Contifier 1 Contifuing Phys	sician: To the best of my liner: On the basis of exam	knowledge, dea ination and/or	ath occurred at the ti	me, date and place opinion, death occ	and due to the urred at the time	ne cause(s) e, date and	and manner as place, and due	s stated. e to the cause(s)
To the within 2 To the comple	Med	29b. Signature and title of certifier	) and manner stated.		29c. Licens	se number 65217		29d. Date	e signed (Mon	th, Day, Year)
6		30. Nam and address of person who co	mpleted cause of death (I MD 200	tem 23a) (Type	LUKE CIR	CLE, WE	STMIN	STER,	MD 2	1158
Stat Registra		31. Date filed (Month, Day, Year)  OCT 2 9 2007	32. Registrar's Si	gnature	de la company de					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 7:55 **Physician** 2007 SHOCKET october HARRY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Salhmone tospital of Ballimore Birthplace (State or Foreign Country) Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours **Funeral** Min. 1 M 2 □ F MD 02/17/1915 212-03-3142 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Director BALTIMORE N/A MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21209 3011 FALLSTAFF ROAD UNIT #203 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. WHITE 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MEN'S CLOTHING VICE PRESIDENT 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ARUK LEAH REBECCA SHOCKET BENJAMIN ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6714 LAURELWOOD AVENUE - BALTIMORE, MD 21209 ROBERT SHOCKET / SON 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of 20a. Method of Disposition BETH EL MEMORIAL
PARK

22. Name and Address of Facility 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) RANDALLSTOWN, MD 10/26/2007 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS.. INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician pilato. /Medical Due to (or as a consequence of): **Examiner** cancer Lung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 XYes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 X No 2 No certificate Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certifica 26. Place of Death (Check only one 25. Was case referred to medical examiner?

1 Yes No Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 2 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of funeral 27. Manner of Death 28a. Date of Injury Certification: (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide filled in by 4 🗌 Homicide To the Hospital of within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2402321 4420774 October

State Registrar

0

YASSAR Y
31. Date filed (Month, Day, Year)

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YOUSSEF

OCT 2 9 2007

Hegistrar's Signature

Division or Vital Records, P.O. Box 68760,

Physician /Medical Examiner The law requires that the death certificate be executed attending physician and for use as the bunal-tran cate has been signed by a page 2 should be detach certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

Example 1 Example Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PO BOX 216

AGATON H, ESCACANTE W. D. 3805 NORRISVILLE NO MARTINIA

Registrar

Medical

31. Date filed (Month, Day, Year)

OCT 2 9



Tasha Greenberg MD. Assistant Medical Examiner

31. Date filed (Month, Day, Year)

32. Jegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

October 21, 2007

State 31. Registrar

OCT 2 OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 28a & 28e, per Fig. 874, 12/13/07 TT

The Amend Items 25,28d, f per me, g8.72,10/29/07dhb

Distrar Reg. No. 17 1- For Amend Items 25,28d, f per me, 8872,107 Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JOSEPH TREMPER 1730 October 2007 /Medical 19 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Johns Hopkins Bayrian Medical 5. Social Security Number 6. Sex 7 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months 1 XM 2 ☐ F Davs Hours October 13, 1924 Maryland 212-20-7463 Director 83 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at show 10d. Inside City Limits Director Harford Joppa MD 1 ☐Yes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be r 21085 **USA** 403 Timber Lane Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: 2 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department Of and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Analyst Defense 12 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be Marie Landerkin Theodore Joseph Tremper ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 Timber Lane-Joppa, Maryland 21085 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an Maren Tremper-spouse 27 20a. Method of Disposition
1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date EVANS FUNERAL CHAPEL AND CREMATION Belair QC+ 23,2007 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o once, Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EVANS FUNERAL CHAPEL 3 Newport Drive Forest Hill, Maryland 21050 AND CREMATION SERVICES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia Physician disease or condition resulting in death) day /Medical Due to (or as a nsequence of): Examiner Neurogenic Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) FRANCIA ROPH OVED BY MEDICAL attending physician and for use as the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month signed by the at Id be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Inknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 ☐ Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has autopsy performed (es 2 No certificate 1□ Yes Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 within 24 hours after death.

To the Funeral Director: After this off pickup truck while triming bushes 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? Certification: Attending 5 ☐ Pending investigation 1 Dratural Injury 1 ☐ Yes 2 ☑ No 2 Accident Unknown 6 ☐ Could not be determined 28f. Location (Street and Number of Fral Route Number, City or Town, State 403, Timber Lane 3 Suicide Place of injury - At hon building, etc. (Specify) At home, farm, street, factory, office 4 Homicide To the Hospital or Street Joppa, MD Untenewin 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
OCT 2 4 2007 indri 4940 Eastern Avenue Baltimore, MD 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Margaret Minnie White 2007 10:00AM 26 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St Agnes Hosportal n/a BALtimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8 / 16 / 1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** 1 ☐ M 2 💢 F 88 Maryland 219-01-7672 **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f shov notified at 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 719 Maiden Choice Lane 21228 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No White Specify. Specify: Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 0 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Wainz Anna Wainz ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 0 4 3 Mary Griffin / Daughter 8514 Green Spring Ct. Ellicott City, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages ' Department of H Important: If ite any injury or ot 10/29/2007 Baltimore, Maryland Most Holy Redeemer ☐Bonation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service License 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 4 days neumanie /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ZUnknown page 2 should Be Completed Demente 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 No Division or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 📉 No 1 🛭 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🖾 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No r death. investigation 2 Accident within 24 hours fiter deal To the Funeral Director 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospita Medical 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner etated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ▶ FEHN: BENRADUANC P22256 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Agnes 40Spital BENRA OGALL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Wetzel October 26,2007 10:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Johns Hopkins Bayview Center BAltimore N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | October 21, 1937 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign **™** M 2□ F Months 70 Mary Land Director 215-34-6118 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Director Maryland Baltimore Dundalk 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or event, the Medical Examiner must be 2107 Cameron Drive 21222 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 □ No
1f Yes, Give
Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examine Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 years Mechanic Auto 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gleonard Wetzel P Dorothy Marie Glass 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Wetzel wife 2107 Cameron Drive, Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crematory 4 Donation 5 Dother (Specify) 31, 2007 Baltimore City, MD. 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 77110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do of enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner NIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed pue Due to (or as a consequence of) Box 68760, attending physiclan Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 ☐ Other (specify) Division or Vital Records, P.O. 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed' 2 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: P 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Matural 2 Accident 5 Pending investigation Injury within 24 hours after death

To the Funeral Director; completely filled in by the f 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D16189 Karken 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

KARICARMO

32. Registrar's Signature

EORGE

2 9 2007

31. Date filed (Month, Day, Year)

7835 Eastpornt m

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician NISOMIERSKI 2007 USEPH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Morningside HNNC triendship touse HANDVER If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 218-01-0553 1**≰**M 2□F Afric 25, 1919 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No TANOVER Be Completed by Funeral Director trundel MATYMOND I TUNE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7548 21076 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces? 1 BYes 2 No Army If Yes, Give Year or Dates: WW T 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steamship 8+4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) orAlesKA 2 MAR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Severn MD 21144 A Nyphew 7801 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State St Strovislaus Cen 10-31-2007 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
TOSCON N. ZANNINO. 21. Signature Funeral Service Licensee 21224 St-BA-1to isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest all e. List only one cause on each line. Approximate nterval Between Onset and Death 23a. Part1. Enter the ise a shock, or be rt fail e Imme Lause (Firm disease or condition resulting in death) Physician yla /Medical a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician as 1 attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregn 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the a rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 1 No 24a Was an 1∐ Yes director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 N 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 🗌 Yes 2 No within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🚅 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier

State Registrar

OCT 2 9 2007

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Dona1d Williams 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Burnie Baltimore Washington Medical Center 61en Anne Arunder 6. Sex 1 M 2 □ F 8. Date of Birth Feb. 20, Year 32 5. Social Security Number if Under 1 Year | if Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. New Jersey 142-24-9563 75 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 No Director New Jersey Sussex Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 07461 34 New York Ave. United States filed within 72 hours after death v Hygiene, Funeral items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 195 If Yes, Give 105 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 7 Is marked other than "natural", or iten traumatic event, the Medical Examiner 1952~ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ If Yes, Give Year or Dates: 1954 White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Drywaller Construction permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Palmer Ottie Williams 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sussex, New Jersey Alice E. Williams / Wife 34 New York Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 4 Donation 5 Dother (Specify) 2007 Catonsville, MD 21. Signature of Funeral Service Licensee Kirkley - Kuddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 disease or condition resulting in death) /Medical Due to (or as consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10 The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760; 11 attending physician for use as the buria Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year signed by the a 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy 2 10 NO 10 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ Ne Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Ampatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Watural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

To the Hospital or Attending Physician; s after death.

I Director: After this of in by the funeral d in by within 24 hours aft

To the Funeral Di

completely filled in

UILLIAMS, DOJGIO

3 Suicide 4 Homicide

29a. Certifier (Check only one) 6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and titl

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Davidson, M.D. 305 Hospital Drive Glen Burnie, MD 21061 31. Date filed (Month, Day, Year) QC I 2 9

State Registrar

Medical

32. Registrar's Signature

and manner stated

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 9:35 P M 2007 Alice Webster October 24, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Berlin Nursing & Rehabilitation Ctr. Berlin If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 M XX F 15,1919 87 Dec. 233-36-7552 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10b County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Berlin Maryland Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 2 and 1 july or other traumatic event, the Medical Examiner must he more. United States 21811 7 Willow Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify. Specify: ò White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry Inspector 8 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ester Elizabeth Rogers Early Bragg ٩ 19a. Informant's Name/Relationship (Type. Print) Granddaugh to Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Berlin, Maryland Mrs. Brenda Archer-Nichols 80 Robin Hood Trail 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ₩Burial 2 □Cremation 3 □Removal from State Meadowridge Mem. Park 10/29/2007 Elkridge, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1, Enter the disease shock, or heart failure. Cardiovasenter Immediate Cause (Final disease or condition resulting in death) Cee Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events recoming in Jean ) Lect Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Be Hospital: 1 ☐ Inpatient Other: 4 Lursing Home 5 Residence 6 Other (Specify) 2) No 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. the 29c. License number 29b. Signa person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

marke

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 26, 2007 **Physician** 8:30 a. M William Webb Woolston, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Care Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Jungalia 5ay, 1912 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday, **Funeral** Months Days Hours 95 Margrand 216-16-1325 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Maral Hyglen Department of Health and Maral Hyglen in "rafural", or items 23a or 28a-f show Important: If its marked other than "rafural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Baltimore Maryland Baltimore 1 ☐ Yes 2√X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21234 8820 Walther Blvd. Apt. 1417 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black White, white, white 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: 1 ☐ Yes 2√No Specify. ģ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Principal Baltimore County Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William W. Woolston, Sr. Naomi Tibbals 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William W. Woolston III/ Son 280 Kingsgate Court Gettysburg PA 17325 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Dulaney Valley Mem. Gardens 10/29/07 Timonium Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (ord comy spath **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any adding to immunitate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 nknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 🗌 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence (Specify) Hospital 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 758303 Ocovor 26 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charle St Donsen Mo J-CHARLES UN 200 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 9 2007

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 34583 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2007 5:00 October | 5, CARMEN ALVARADO /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Forest Glen Nursing & Rehabilitation Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Min. Days Hours Months 1 ☐ M 2 🖼 F 577-76-7540 Yrs. Trinidad Director Jan 31, 1924 83 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show rthen "naturel", or iteme 23e or 28a-f ehov the Medical Examiner must be notified at 1 ⊊Yes 2 ☐ No Silver Spring Directo Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20910 Trinidad 2700 Barker Street filed within 72 hours after death Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify: **Black** ģ 3 → Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If Item 27 is marked other t ijury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1001 Connecticut Ave, NW #1137 Washington, DC 20036 Allison Alvarado - Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Oct. 25, 2007 Clinton, MD Resurrection Cemt. 21. Signature of Funeral Service 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, is ading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed burial-translt Due to (or as a consequence of) Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒No 3 Ectopic pregnancy Year Month Day be detached for 4☐Pregnant at time of death 5 Other (specify) o 9☐ Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this : After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation To the France.

Within 24 hours after death.

To the Funeral Director: After the funeral on by the funeral of t 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Ecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Mano October 11, 2007 D56691 30. Name and a sess of person who completed cause of death Third 23a) (Type, Print) P.A. 12107 Heritage Park Circle Silver Spring, MD 20906 Ghousia Sultana, M.D., 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2342 OCT 2 9 2007 Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

	4.5 4.0 41	1 41				Death	2. Dete of De	Reg. Na	J	3. Time of Death
hysician	Decedent's Name (First, Middle,						Month. Octobe		Year	5:00am
/Medical	Michael	Aja			- 1	b. City. Town, or L				3 · 0 0 dam
xaminer	4e Fecility Neme (If not institution, 7855 Riverdal				"	Riverdal		Prince		rge's
			je (In yrs. last bi	irthdey) If Unde	r 1 Year	If Under 24 Hrs.	9 Date of Bir	th		
neral ector	074-88-2580	18 M 2□ F 4(		Yrs. Months		Hours Min.	Feb I	4 <sup>4</sup> 1967	Nige	ace (State or Fore Y1a
3	Usuel Residence of Decedent  10a. State 10b. County			vn or Location					10	0d. Inside City Lim
cto	MD Prince	George's	New	Carrol1						
ai Dire	10e. Street and Number 7855 Riverdale	Road # 103			p Code 0784			10g. Citizen of V		try?
Evaminer must be notified by Funeral Director	11. Maritel Status  1 Never Merried 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? ed 15 Yes 2 1 If Yes, Give Year or Detes:	Ever in U,S. No Navy	13. Was Dece If Yes, spo		spenic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Specify	e - America sk, White, 6 B1	
event, the Medical is	15. Decedent' (Specify only highest	t grede completed)	168	a. Decedent's Usi (Give kind of w life. DO NOT	uel Occup ork done o use retired	ation during most of work )	king	16b. Kind of Bu		lustry
E W	Elementary/Secondary (0-12)	College (1-4or)	rs .	Air Craf	t Ha	ndler		Govern	ment	
important: if item 27 is marked other than "natural", or fams 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	17. Father's Name (First, Middle, L	.ast)				18. Mother's Nam			10)	
	Samuel Ajayi					Beatri	ce Osas	sona		
	19a, Informant's Name/Relationsh	nip (Type, Print)				and Number or Ru				
rtrail	Elizabeth Ajayi		7	855 Rive	rdal	e Road #	103 Ri	verdale,	Mary1	and 2078
ry or other	20a. Method of Disposition  1X Burial 2 Cremation  4 Donation 4 Other (Sp	3 □Removal from State	20b. Place	of Disposition (Na	ame of	e) 1 Cemete	Date	20c. Location -	City or To	wn, State
eny injur once.	21. Signature of Fur eral Service I			22. Name a	and Addre		B. Je	nkins Fu	neral	Home
	23a. Parli. Enter the disease, of c	LXC		1					y Lamo	Approximete
physician end six the bunel-transit six the bunel-transit edical Examiner	resulting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause, (Disease or injury	b		a consequence of						
2 0 00 00 00 00 00 00 00 00 00 00 00 00	Cause (Disease or injury									
nding pnysicial use es the bur n/Medical	that initiated events resulting in death) Last	d	Due to (or as a	consequence of	):					
d for use es the iclan/Medic	resulting in death) Last					en in Part I.	23b. Dic	tobacco use co	ntribute to	o the cause of de
deteched for use es the deteched for use es the	that initiated events					en in Part I.				
peen signed by the ettending thould be deteched for use e thould be deteched for use efted by Physician/M	resulting in death) Last					en in Part I.	1 [ 24a. Wa		3 ☐ Proi	bably 45 Unki
ss been signed by the ettending 2 should be deteched for use e ipieted by Physician/M	resulting in death) Last					en in Part I.	1 [ 24a. Wa per	Yes 2□ No	3 Prof	bably 45 Unki
ss been signed by the ettending 2 should be deteched for use e ipieted by Physician/M	Part II. Other significant condition					en in Part I.  26. Place of Dea	1 = 24a. Wa	Yes 2 □ No s an autopsy ormed?  Yes 2 ≅ No	3 Prof	ere autopsy findinaliable prior to mpletion of cause deeth?
ss been signed by the ettending 2 should be deteched for use e ipieted by Physician/M	Part II. Other significant condition		out not resulting	in the underlying	cause giv	26. Place of Dea	1 ☐ 24a. Wa per 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1	Yes 2□ No s an autopsy ormed?  Yes 2 ♣ No one)	3 Proi	ere autopsy findinaliable prior to impletion of cause deeth?
Inis certificate has been signed by the effecting all director, page 2 should be deteched for use e. To Be Completed by Physician/M	Part II. Other significant condition  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending	Hospital: 1 Inpati	out not resulting	in the underlying	OOA Ott	26. Place of Dec	1 ☐ 24a. Wa per 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1	Yes 2 □ No s an autopsy ormed?  Yes 2 ♣ No one)	3 Proi	mpletion of cause deeth?  ☐ Yes 2 No
Inis certificate has been signed by the effecting all director, page 2 should be deteched for use e. To Be Completed by Physician/M	Part II. Other significant condition  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Namer of Death	Hospital: 1 Inpati  28a. Dete of Injugation not be 28e. Piece of In	out not resulting ient 2□ ER/0 ury ay Year)	in the underlying	DOA Offi	26. Place of Dea ier: 4□ Nursing H	1 Cath (Check only lome 5 🖺 Re: 28d. Describe	Yes 2□ No s an autopsy ormed?  Yes 2 ♣ No one)	3 Proi	ere autopsy findin allable prior to mpletion of cause deeth?  Yes 2 <sup>15</sup> No
Inis certificate has been signed by the effecting all director, page 2 should be deteched for use e. To Be Completed by Physician/M	Part II. Other significant condition  25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  27. Manner of Death 1 ☒ Natural 5 ☐ Pending investig 3 ☐ Suicide 6 ☐ Could n determi	Hospital: 1 Inpati  28a. Dete of Injugation not be 28e. Piece of In	ient 2 ER/Cury 28b siy Year) 28b siyry - At home, fc. (Specify)	in the underlying  Outpatient 3 1.  Time of Injury M  farm, street, factors death occurre	DOA Office	26. Place of Dea ier: 4 □ Nursing H y at k? Yes 2 □ No	24a. Wa per 1 Cath (Check only tome 5 A Rec 28d. Describe 28f. Location City or To	Yes 2 No s an autopsy ormed?  Yes 2 No one) sidence 6 Otto how injury occur (Street and Num. own, State)	24b. W. av co of 1[	ere autopsy findin aliable prior to mpletion of cause deeth?  Yes 21 No
Inis certificate has been signed by the effecting all director, page 2 should be deteched for use e. To Be Completed by Physician/M	Part II. Other significant condition  25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  27. Manner of Death 1 ☒ Natural 5 ☐ Pending investig 3 ☐ Suicide 6 ☐ Could n determi	Hospital: 1 Inpati  28a. Dete of Injudicion into be inted  28e. Plece of Inbuilding, e  28physician: To the best examiner: On the basis of and manner s	ient 2 ER/Cury 28b siy Year) 28b siyry - At home, fc. (Specify)	in the underlying  Dutpatient 3 0  Time of Injury M  farm, street, factors  ge, death occurres and/or investigation	DOA Otto	26. Place of Dea ier: 4 □ Nursing H y at k? Yes 2 □ No	24a. Wa per 1 Cath (Check only tome 5 A Rec 28d. Describe 28f. Location City or To	Yes 2 No s an autopsy ormed?  Yes 2 No one) sidence 6 Otto how injury occur (Street and Num. own, State)	24b. Wave cooper of 1[	ere autopsy findin allable prior to mpletion of cause deeth?  Yes 21 No  Ty)  Al Route Number, stated.  o the cause(s)
To the Funeral Director: After this Sefriticate has been signed by the ettending completely filled in by the funeral director, page 2 should be deteched for use a Medical Certification: To Be Completed by Physician/M	Part II. Other significant condition  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n determi  29a. Certifier 1 Certifying (Check only one)	Hospital: 1 Inpati  28a. Dete of Injudicion into be inted  28e. Plece of Inbuilding, e  28physician: To the best examiner: On the basis of and manner s	ient 2 ER/Cury 28b siy Year) 28b siyry - At home, fc. (Specify)	in the underlying  Dutpatient 3 to 1. Time of Injury M  farm, street, factor and/or investigation 1. 2	DOA Ott  28c. Injun  ory, office  d at the tiinn, in my office	26. Place of Dealer: 4 □ Nursing Hy at k? Yes 2 □ No	24a. Wa per 1 Cath (Check only tome 5 A Rec 28d. Describe 28f. Location City or To	Yes 2 No s an autopsy ormed?  Yes 2 No one) sidence 6 Ott how injury occur (Street and Num. State) e cause(s) and men, date and place,	24b. Wave cooper of 1[	ere autopsy findin allable prior to mpletion of cause deeth?  Yes 21 No  Ty)  Al Route Number, stated.  o the cause(s)
Inis certificate has been signed by the effecting all director, page 2 should be deteched for use e. To Be Completed by Physician/M	Part II. Other significant condition  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n determi  29a. Certifier 1 Certifying (Check only one)	Hospital: 1 Inpati gation not be ined  28e. Piece of Ini building, e  g Physician: To the best examiner: On the basis of and manner s	ient 2 ER/Cury 28b sy Year) 28b signy - At home, fc. (Specify) of examination a tated.	in the underlying  Dutpatient 3 1  Time of Injury M  farm, street, factor ge, death occurre	DOA Ott  28c. Injun  ory, office  d at the tiinn, in my office	26. Place of Dea	24a. Wa per 1 Cath (Check only tome 5 A Rec 28d. Describe 28f. Location City or To	Yes 2 No s an autopsy ormed?  Yes 2 No one) sidence 6 Ott how injury occur (Street and Num. State) e cause(s) and men, date and place,	24b. Wave cooper of 1[	ere autopsy findir ailable prior to mpletion of cause deeth?  Yes 2 No  No  No  Route Number, stated. o the cause(s)

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** October 22 2007 Benningfield Lamont Edgar /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1**X** M 2 ☐ F Sept.13, 72 1935 Kentucky 402-42-2998 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☑Yes 2 ☐ No Director MDWashington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 105 West Side Ave. 21740 U.S.A. Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify. Specify: White Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Operator Water-Sewage 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Talley Donie Benningfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Virginia L. Benningfield/Wife 105 West Side Ave., Hagerstown, MD 21740 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery | 10/25/2007 | Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): PNEUHONIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner CANCER BY HISTORY be executed burial-transit and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Year in the past 12 months? ed by the a 2 ☐ No P.O. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 2 No 26. Place of Death (Check only one) the Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 1 ☐ Yes Certification: To 28d. Describe how injury occurred 27. Manus of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? After (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier f ron who completed o alise of death (NG TON) WA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrat

		_	For State Registrar	State of I	Marylan		artment of tificate				R	eg. N2 0 0 1	
	Physicia	20	1. Decedent's Name (First, Middle,								<ol><li>Date of Dea Month</li></ol>	th Day Year	3. Time of Death
	/Medic	al	WILLIAM MCK								Octobe		
}	Examin	er	4a. Facility Name (If not institution.		ər)		4b. City, To	wn, or Lo Ltefo		Death		4c. County of Dea	
			1640 Main Stre		Age /In urs	last birthday)	If Under 1		f Under 2	4 Hrs.	8. Date of Birth		nthplace (State or Foreign
	Funeral Director		235–28–1847	X□M 2□F	85				Hours	Min.	8. Date of Birtl (Month, Day 9/29/19	, Year)	ountry) st Virginia
			Usual Residence of Decedent								-,, -		
	nylan ihow		10a. State 10b. County	_	10c. Cit	y, Town or Lo							10d. Inside City Limits
	88-f	Director	MD Harfo	rd —————		Whit	eford						
	within 72 hours after deeth with the Maryland ene. Than "naturel", or Iteme 23a or 28a-f show he Modicel Examiner must be notified at	ai Dire	10e. Street and Number 1640 Main Str	eet			10f. Zip C	160				10g. Citizen of What C	
	lteme	Funeral	11. Marital Status	12. Was Decede Armed Force d 1 1 1 1 1 1 1 1 2 1 1 1 1 1 1 1 1 1 1	s?	.S. 13.	Was Deceder If Yes, specify	nt of Hispa Cuban, I	a <i>n</i> ic Orig Mexican,	in? (Spe Puerto F	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date		Г	1 ☐ Yes 25	₹ No S	Specify:			Specify: W.	hite
21215-0036	2 hou	ted	15. Decedent's		*****	16a Dece	dent's Usual	Occupatio	on ing most	of working	10	16b. Kind of Busines	s/Industry
215	I within 72 ho liene. r than "natur ine Wedicel	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4	or 5+)		kind of work DO NOT use DIV Lil				9	Manufact	uring
C	filed with Hygiene. other the	Co	8			ASSER	OTA DI				/First Middle	Maiden Sumame)	WI 1119
	e d la b	Be	17. Father's Name (First, Middle, L William Patto					18			te O'N		
Ž	s 1 and 2 should f Health and Men from 27 ie marke other treumatic	၉	19a. Informant's Name/Relationshi			19b. Maili	ng Address (	Street and	d Numbe	r or Rura	Route Numbe	r, City or Town, State,	Zip Code)
	nd 2 lith a 27 Is		Yvonne Bishop/W	ife		1640	) Main	Stre	eet,	Whit	eford,	MD 21160	
re,			20a. Method of Disposition		20b. F	Place of Dispo cemetery, cre-	osition (Name matory or oth	of er place)	I	D	ate	20c. Location - City of	r Town, State
E	Pages nent of I ant: If Ite ury or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		" Higl	hview D	Mem. Ga	arden	ns   1	10/26	5/07	Fallston,	MD
Baltimore,	permit. Page Depertment of Important: If eny injury or QDCE.		21. Signal re Funeral Service L	censee	201	17	2. Name and Harkin				me, Inc	., Delta,	PA 17314
			23a Parti. Enter the disease for concern the concern the concern that the concern the concern that the conce	complications that cau	sed the death line.								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition								DISCAS		Onset and Death
	/Medical Examiner		resutting in death)		as a consec								
	LXMIIIICI	76	Sequentially list conditions, if any, leading to maneurate	b. Due to for	35 2 OU 500	suanca offi					-		
7	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
·	ate be executed hysicien and the burial-transit	Exa	resulting in death) Last	C. Due to (or	as a consec	quence of):							
68760,	ate be hysici ihe bu	Icai	,	d							· · · · ·		
9 ×	ertifica ling pl	Med	IF FEMALE:	23c. If ves. outco	ma of oroso	0001						and Date of a	
Box	The law requires that the deeth certificate be executed tere has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birt	h 2 ☐ Feta it at time of c	al déath 3 [	□Ectopic pred □ Other (spec					23d. Date of d Month	Day Year
P.0	that the dered by the a	Phy	9 Unknown  Part II. Other significant condition	s co <i>atá</i> butina to deal	th but not rea	sulting in the u	inderlying cai	use given	in Part I.	-	23e. Did t	obacco use contribute	to the cause of death?
of Vital Records,	w requires tha been signed I should be det	ed by	DIAheres								10	/es 2□No 3□	Probably 4 QUnknown
ဝ၁	re law requ has been ge 2 shoulk	Completed									24a. Was	an 24b. Were	autopsy findings available o completion of cause of
Ä	The The ste hg	E O									perfo 1 ☐ Yes	rmed? death	?
/ita	Physician: Th this certificete ral director, pag	Be (	25. Was case referred to medical examiner?					-		of Death	(Check only o	nne)	
=	Physic this c	2	1 Yes 2 No			ER/Outpatie			4 🗆 140			dence 6 Other (Sp	pecify)
NC O	After After fune	lon;	27. Manner of Death   Natural 5 Pending		Day Year)	28b. Time of Injury	M 28	c. Injury a Work?	ıt es 2∐l		zag. Describe	now injury occurred	
Division	t or Attending efter death. Director: After In by the fune	fical	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place o	f Injury - Al h	nome, larm, si						Street and Number or	Rural Route Number,
<u>S</u>	etor s effer	Certification;	4 Homicide	building	, etc. (Speci	ify)					City or To	wn, State)	
	To the Hospitel or Attend within 24 hours effer death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the be xaminer: On the bas and manne	is of examin	owledge, dea ation and/or ii	th occurred a nvestigation, i	t the time, n my opin	, date an nion, dea	d place, th occurr	and due to the ed at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
T	To the To the complex	Me	29b. Signature and title of certifier				29c.	License n	number			29d. Date signed (Mo	nth, Day, Year)
6	)		> Down 5	Dun.				032	211	Š.		OCTUBER	22, 2004
,	5		30. Name and address of person of	,	of death (Ite	m 23a) (Type	, Print)	34			c m	> 9101A	
	Str	ate	31. Date filed (Month, Day, Year)		gistrar's Sign		TRY.	W.	UK	1 110	1	5 6.0.	•
	Regist		ACT 2 G	2007	0	it A	mandi s						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 250 PM Year CHARLES E. BARBEN, SR. 2007 tober 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death tartora Bel Air Health and Rehab Center If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/11/1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Min. 1 X M 2 □ F 197-07-5428 91 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Whiteford Harford 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1410 Old Pylesville Road 21160 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Agricultural Chemicals Packager 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Warren Leo Barben Cora Mae Cantler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Betty M. Gray/Daughter 1522 Main Street, Whiteford, MD21160 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/25/07 Slate Ridge Cemetery Delta, PA 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, ean Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 Probably 4 ☐ Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

٩

MD

**Funeral** 

Director

should be filed within 72 hours after death with the Maryland

3altimore,

of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

68760, Box 0 hari Vital ö Division

permit. Pages 1 Department of H Important: If Iter any injury or oth 21. Signature of Funeral Service Licenses art1 E the disease, or control a shock, or heart failure. List only one mmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transi that initiated events resulting in death) Last Completed by Physician/Medical IF FEMALE: 23h. Was decedent pregnant in the past 12 months? been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 28d. Describe how injury occurred 27 Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? Certification: Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No i Director: A d in by the fu 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

OCT 2

9 2007

308 (Sus 32. Registrar's Signature

		State of Maryland / Dep. 1 - State Registrar Amend #12 per FH G872 10/28/8	artment of Health and N <b>Micell</b> e of Death	Mental Hygiene	07 34588			
Physi /Med		1. Decedent's Name (First, Middle, Last)  Joseph J. Bakali	.k	2. Date of Death Month Day October 9,				
Exam		4a. Facility Name (If not institution, give street and number) 839 Johnson Road	4b. City, Town, or Location of Death Salisbury	W:	unty of Death			
Funera Directo		5. Social Security Number 216-01-3479  6. Sex 1 M 2 □ F  7. Age (In yrs. last birthday, Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Year) 12/17/1917	9. Birthplace (State or Foreign Country)  Mississippi			
faryland show	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  Maryland Wicomico Salisbu:			10d. Inside City Limits 1 □XYes 2 □ No			
with the had or 28a-f	Direct	10e. Street and Number 839 Johnson Road	10f. Zip Code 21804	_	n of What Country?			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural", or items 23a or 28a-f show eny injury or other treumatic event, it a Medical Examination and item of the rediffical in	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Mes 2 He of Forces.   Was Decedent of Hispanic Origin? (State of Hispanic Origin?) (State of Yes, specify Cuban, Mexican, Puerto of Yes 2 ▼ No Specify:	Rican, etc.)	Race - American Indian, Black, White, etc. pecify: white				
Baltimore, Maryland 21215-0036 Demit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hylgiene. Important: if Item 27 is marked other than "netural", or any Injury or other treumatic event, the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired) 'tsman/engineer	king	of Business/Industry e of Maryland			
and 21 ibe filed v ntal Hygie ed other i	Be	12 – Drai 17. Father's Name (First, Middle, Last)  John Bakalik		ne (First, Middle, Maiden Su				
Maryla d 2 should th and Mer 7 is marke	7	19a Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Ru 9 Johnson Rd., Sa.	ral Route Number, City or T	own, State, Zip Code) 1804			
ages 1 and of the all		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition cemetery, critical 2 Street Place of Disposition 2 Removal from State	ematory or other place)		sbury, MD			
Baltin permit. P Departme importan eny Injury	- Supplemental Control	21. Signature of Funeral Service Librarie  (F10)	ry Crematory   10/ 22 Name and Address of Facility 1   Holloway Funeral   501 Snow Hill Rd.					
Physicia	n	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Finaf disease or condition	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death			
/Medica Examine		resulting in death)  Due to (or as a consequence of).  Sequentially list conditions,						
8760, sate be executed only sician and the burial-transit	al Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseaseror injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):						
Box 6 death certific e attending p	Physician/Medical		☐Ectopic pregnancy	23	23d. Date of delivery Month Day Year			
rds, P. Iuires that n signed b	ē	Part If, Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use	e contribute to the cause of death?			
Il Records, P.O. The law requires that the ate has been signed by the page 2 should be detached.	Completed	Ancinca Senata		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 2 No			
f Vita lysician: is certific director.	o Be	25. Was case referred to medical examiner?  1   Yes   2   No	ient 3 DOA Other: 4 Nursing I	ath (Check only one)  Home 5 Residence 6  28d. Describe how injury				
Division of Attending after death. Director: After din by the fune	Certification:	2 Accident investigation   M   1   Yes 2   No    3   Suicide   6   Could not be determined   28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   28f. Location (Street and Number or Rural RocCity or Town, State)						
ospita hours unerally filled	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de (Check only one)  2 Medical Framiner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place investigation, in my opinion, death occ	urred at the time, date and p	place, and due to the cause(s)			
To the Ho Within 24 To the Fu complete	×	29b. Signature and title of certiful	29c. License number	29d. Date	signed (Month, Day, Year)			
Sp	1	30. Name and address of person the completed cause of death (frem 23a) (Type	De, Print) 3(11 Cars)	al they	Ocen City 218			
The Control of the Co	State istrar	31. Date filed (Month Day Year) 2 2007 32 Resident's Signature	Sand					

State Registrar 30. Name and

REDDY, M.D. 6320

32. Pegistrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32. Degi

AJAY

2. Degistrar's Signature

Reference St Sparke

OCT. 12, 2007

DEMOCRACY BLVD., BETHESDA, MD. 20817

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3G-/Medical 4a. Facility Name (If no institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🛛 F 29, Director 577-38-2435 79 June 1928 Washington, DC Usual Residence of Decedent death with the Maryland 10c, City, Town or Location show 10a State 10b. County 10d. Inside City Limits "naturai", or items 23a or 28a-f shov idical Examiner must be notified at 1 ☐ Yes 2 XNo Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3310 N. Leisure World Blvd., #523 20906 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1 No ğ Specify: Specify: White 3<sup>th</sup> Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own\_Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Matthew Yingling Louise Harrington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Douglas E. Berry/Son 17534 Gatsby Terrace, Olney, Maryland 20832 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 19 Oct. 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 2007 Silver Spring, Maryland 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, 21. Signature of Funeral Service Licensee 5 MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) NON /Medical Due to (or as a consequence of): Examiner 9 Sequentially list conditions, france leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ^ Examiner sician and burial-transit Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1☐Yes 2☐No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed Be Certification: To

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

death certificate be executed 24 hours after death. Prineral Director: After To the Hospital or At within 24 hours after of To the Funeral Direc

12%

Medical

			<u> </u>
Chronie Fibrill	2 tion tindoca	24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical examiner?		26. Place of Death (Check only one)	
1 Yes 25 No	Hospital: 1 → npatient 2 □ ER/Outpatient 3 □ DOA	Other: 4 Nursing Home 5 Residen	ce 6 ☐Other (Specify)
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	Injury at Work? 28d. Describe how	injury occurred
3 Suicide 6 Could not be 4 Homicide determined		ice 28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of my knowledge, death occurred at the miner: On the basis of examination and/or investigation, in and mapper stated	ne time, date and place, and due to the cau my opinion, death occurred at the time, dat	se(s) and manner as stated. e and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year) Octobe 12 7007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18109 Prince Philip Drive, #225, Olney, MD 20832 Reed Shnider, MD

31. Date filed (Month, Day, Year) State I 5 Registrar

32 Registrar's Signature

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 3:02平M DONG sther 3 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, Yea 06/03/1920 If Under 1 Year | If Under Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Min. Months Days Hours 1 □ M 2 🕱 F 87 NEW YORK Director 123-12-5745 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County TXTYes 2 □ No Directo MARYLAND MONTGOMERY ROCKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or 1801 EAST JEFFERSON STREET #103 20852 USA Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Int. If Item 27 Is marked other than "natural", or items 23 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or items edical Examiner n Black, White, etc. 1 □ Never Married 2 □ Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify δ Year or Dates: 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TEACHER **EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental h LOUIS FARBER ANNA KOHN ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DANIEL A. BONDY - SON 7559 HEATHERTON LANE, POTOMAC, MARYLAND 20854 permit. Pages 1 and. Department of Health important: if Item 27 any Injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State MOUNT LEBANON CEMETERY 10/15/2007 ADELPHI, MARYLAND 4 Donation 5 Dother (Specify) 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. Signature of Europal Service Licensee 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardia ute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner oronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🖾 No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 은 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C Hospital 29a. Certifier TV Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 ☐ Medical Examiner: On the basis of exa pination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifie 29c. License number To D40365 Oct 13 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1400 Forest Glen Rd #200 Silver Spring ET 213 B313 WD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 15 2007 PUNT Registrar

07-07953 Melvin Donell Byrd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 34592 Certificate of Death 1- For State Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month 2305 hrs DARNELL October 10, 2007 BYRD Medical Examiner MELVIN 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Temple Hills 2805 Kennel Lane 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 6 Sex 7. Age (in yrs. last birthday) 5. Social Security Number **Funeral** Foreign Country) Months Days Hours 07/27/1966 VA Director 248-29-6887 41 1× M Usual Residence of Deceden 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 No "natural", or items 23a or 28a-f show Examiner must be notified at once. MD Prince Georges Oxon Hill Baltimore, MD 21215-0036
pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20745 USA 5446 Woodland Blvd. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No. Funeral 11. Marital Status 12 Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Ves Black 1 Yes 2 X No specify: Specify: If Yes. Give Year Divorced Widowed à 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Building Elementary/Secondary (0-12) College (1-4 or 5+ Electrician Construction 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Priscilla Byrd Harry Franklin Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ۵ 5446 Woodland Blvd., Oxon Hill, MD\_20745 Harry Franklin/ Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State crematory or other place) 10/20/07 Alexandria, VA Cemetery Bethel Donation 5 Other Specify. 22. Name and Address of Facility Greene Funeral Home 21. Signature of Funeral Service Licenses E Street 814 Franklin Street, Alexandria, VA 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Death a. Asphyxia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) b. Hanging Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initialed Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED UNPENDED 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death?

attending physician and or use as the burial - tran signed by the atte certificate h this After To the Funeral Director: completely filled in by the

The law requires that the death certificate be

the Hospital or Attending Physician:

To

death.

hours after

Division of Vital

Box 68760

o

Records, P.

þ Completed Be Certification:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medical Other<sub>4</sub> Hospital: 1 Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 27. Manner of Death Subject found hanging FOUND: Natural Yes 2 🗸 No 5 Pending Oct 10, 2007 2255 hrs 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 2805 Kennel lane, Temple Hills, MD 3 V Suicide determined (Specify) Vacant Building 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) **ÓRIGINAL** 

30. Name and address of person who completed cause of death (Item 23a)

Nuch

**OCME** 

O.C.M.E.

24b. Were autopsy findings available prior to completion of cause of

2 No

death?

October 12, 2007

Yes

State Registrar

# State of Maryland / Department of Health and Mental Hygiene

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

	For State Registrar			rtificate of De		Reg. N	0007	34593		
an	1. Decedent's Name (First, Middle, Last)	- 1					ay Year	3. Time of Death		
al	John Malcolm					October 9	2007	2:15 a. <sup>M</sup>		
er	4a. Facility Name (If not institution, give s			4b. City, Town, or Lo		4	c. County of Death	tor		
- 4	Dorchester Gene 5. Social Security Number 6. Sex		last birthdav)	Cambridge If Under 1 Year   If Under 24 Hrs.   8. Date of Birth			Dorches 9. Birthr	place (State or Foreign		
		M 2□F 55	Yrs.	Months Days H	Hours Min.	Jan. 21,	1952 Mar	yland		
tor	10a. State 10b. County MD Dorches		ty, Town or Lo		ew Marke	et		10d. Inside City Limits 1⊈Yes 2 ☐ No		
al Direc	10e. Street and Number 63 Sugar Drive			10f. Zip Code	631	10g. C	g. Citizen of What Country? USA			
Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hispa If Yes, specify Cuban, I 1 ☐ Yes 2🌠 No S	anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: whi	etc.		
pleted t	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced (Give life. I	dent's Usual Occupatio kind of work done duri DO NOT use retired)	n ing most of worki	ng 16b.	Kind of Business/In	dustry		
Com	12	College (1-401 54)	t	cimberman			lumber			
To Be	17. Father's Name (First, Middle, Last) Paul C. Brake			18		(First, Middle, Maide Anspach	en Surname)			
F	19a. Informant's Name/Relationship (Typ	pe. Print)	19b. Mailir	ng Address (Street and	Number or Rura	al Route Number, City	or Town, State, Zij	o Code)		
	Donna Brake	wife		gar Drive,						
	20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State		osition (Name of matory or other place) Market Cem			Location - City or To st New Ma			
	21. Signature of Funeral Service License		22	2. Name and Address of	of Facility Tho	mas Funer	al Home P	P.A.		
	23a. Part T. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	cations that caused the deate cause on each line.  Due to (or as a egnsor	th. Do not ent	^	such as cardiac c	or respiratory arrest,		Approximate Interval Between Onset and Death		
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of o	al death 3 [	□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	rery Day Year		
ed by PI	Part II. Other significant conditions cor	ntributing to death but not res		Inderlying cause given i	in Part IC	23e. Did tobacco		the cause of death? bably 4 □Unknown		
complet	Circhosos Eson Gastinic wice	, GI bles	T201	h telas	et.	24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of		
Be (	25. Was case referred to medical examiner?			20	6. Place of Death	(Check only one)				
To	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	LEB/Outpatier			me 5 🗆 Residence	6 □Other (Spec	ify)		
ation:	27. Manner of Death  1 ☐ Hatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work?	t s 2 No	28d. Describe how in	jury occurred			
Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Speci	nome, farm, sti	reet, factory, office		28f. Location (Street City or Town, Sta	and Number or Rui ate)	ral Route Number,		
dical (		sician: To the best of my kn ner: On the basis of examin and manner stated.								
Me	296. Signature and title of certifier	MD		29c, License n	376	D   D	Date signed (Month	, Day, Year)		
	30-Name and address of person who co Sohail Aman, M.D.				, MD 21	613	/ - /	,		
ite	Sohail Aman, M.D. 503A Muir St., Cambridge, MD 21613  31. Date filed (Month, Day Year) 32. Registar's Signature									

Sta Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 34594 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Day Brown Oct 6 2007 Donald 11:40 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis HealthCare - The Pines Easton Talbot If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 1 1 M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 218-32-9208 May 28, 1937 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ? is marked other than "natural, or Items 23a or 28e-f show treumatic svent, the Modical Examinar must be notified at 1 Yes 2 No Talbot WD deeth with the Mai Completed by Funeral Director Trappe 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4210 Street 216 12. Was Decedent Ever in U.S. Amed Forces? Ja N° 1 WYes 2 No 1957 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify If Yes, Give Year or Dates Sept. 1957 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Trash Removal 10 Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peges 1 and 2 should be fil ment of Heelth and Mental H tant: If Itsm 27 Is marked ott Be Walter R, Brown ara 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2: Department of Heelth ar Important: If Itsm 27 Is sny Injury or other treugones. Brown Shirley Trappe, Maryland 21673

Pate 20. Location City or Town, State 4210-Main Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Veteran's Cemetery 10/15/07 Hurlock, Maryland 4 Donation 5 Other (Specify) 22. Name and Address - acility 21. Signature of Funeral Service Licensee HENRY FUNERAL Home, P.A. 23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Uremia **Physician** weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner physiclan and the burial-transit or Attending Physicism: The law requires that the death certificate be executed personsion P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 2 | Fetal death in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No this certificate hes been si ral director, page 2 should I 24a. Was an autopsy performed?
1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2X No 25. Was case referred to medical 26. Pface of Death (Check only one) Hospital: 1 Inpatient Other 42 Nursing Home 5 Residence 6 Other (Specify) 20 No Medical Certification; To 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier of death (ftem 23a) (Type, Print) ROWLE DUTCHMANS

DHMH 17 Rev 1/2001

State Registrar

	1	For State Registrar		partment of Health and Mertificate of Death	Reg. N	.2007 34595
Physicia	n	1. Decedent's Name (First, Middle, Last)  Alice W		Ballard	2. Date of Death Month October	3. Time of Death 15,2007 10:30a <sup>M</sup>
/Medica	31	ta. Facility Name (If not institution, give stre		4b. City, Town, or Location of Death	4	c. County of Death
Examine		Sacred Heart Ho	me	Hyattsville		rince Georges
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda 93 Yrs.	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 0 3 / 23 / 19	9. Birthplace (State or Foreign Country) 14 Maryland
0		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or			10d. Inside City Limits
Aaryla f sho ed at		Maryland Prince G	eorges Lanham	n		1 <b>X</b> Yes 2 □ No
the N 28a- notif	rec	10e. Street and Number	,co1 900	10f. Zip Code		Citizen of What Country?
3a or		7906 Desen Drive	2	20706		USA
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importants if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	필	1 ☐ Never Married 2 ☐ Married	. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> <li>1 ☐ Yes 2 ☒ No Specify:</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  SpecifyBlack
2 hours natural", ical Exal	ted by	3 X Widowed 4 □ Divorced  15. Decedent's Educat (Specify only highest grade c	Year or Dates:	cedent's Usual Occupation ive kind of work done during most of work 2. DO NOT use retired)	16b.	Kind of Business/Industry
thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		I .	elf-Employed
ed wi	ਨੂੰ -	12 17. Father's Name (First, Middle, Last)	на:	ir Stylist 18. Mother's Nam	e (First, Middle, Maid	
d be fill ental H ked oth	Be		M:	akle Emeline		Wright
should Me mark mark imatic	٩	Garfield  19a. Informant's Name/Relationship (Type	Print) 19b. Ma	ailing Address (Street and Number or Ru	ral Route Number, City	y or Town, State, Zip Code)
INION DE SE LA SET LA S		Romaine Pinchbacl	k/Daughter 790	6 Desen Drive La	nham,Mar	yland 20706
of Hear		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Rer	20b. Place of Di	sposition (Name of crematory or other place)	Date 20c.	Location - City or Town, State
Page Trent and and III		4 ☐ Donation 5 ☐ Other (Specify)	Resurr			inton, Maryland
permit. Pages Department of Important: If it any injury or of		21. Signature of Funeral Service Licensee	191	22. Name and Address of Facility Ac 20605 Aquasco Ro	Aquaso	o, Maryland 20608
2 9	X 13	23a. Fart Enter the Asease, or complications, or heart fillure. List only one	ations that caused the death. Do not cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death  Un Known
Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):	arsease		UKKKOO
Examiner		h				
D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence of):			
&/oU, cate be ex chysician a	ai E		,			
physicate s the	edical	d.				
BOX 6 leath certific attending F	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome pf pregnancy	3 □Ectopic pregnancy		23d. Date of delivery  Month Day Year
. 0 0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	5 Other (specify)		Month Day Year
Division or Vital Records, P.O. I or Attending Physician: The law requires that the de after death. I Director: After this certificate has been signed by the and in by the funeral director, page 2 should be detached in by the funeral director, page 2.	Phy	Part II. Other significant conditions cont	ributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
dS, lires t signe d be c	d by	Severe de	mentia		1 ☐ Yes	2 No 3 Probably 4 Unknown
w requ	Completed	Severe de Failure t Hy pen te	o thrive		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
VITAI HEC sician: The law s certificate has b lirector, page 2 s	duc	Hy new to	ension		performed	death?
ital an: 1 tifficat tor, p	Be C	25. Was case referred to medical		26. Place of De	ath (Check only one)	
ysici nysici nis cel direc	<u>면</u>	TI Tes ZINO	ospital: 1   Inpatient 2   ER/Outp		7-	e 6 Other (Specify)
ng Pl	::uo	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tir		28d. Describe how	injury occurred
SiO ttendi death.	cati	Accident investigation  3 Suicide 6 Could not be	28e. Place of injury - At home, farm		28f. Location (Street	at and Number or Rural Route Number,
DIVI	Certification: To	4 ☐ Homicide determined	building, etc. (Specify)		City or Town, S	State)
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier (Check only one)  Certifying Phys	iclan: To the best of my knowledge, her: On the basis of examination and, and manner stated.	death occurred at the time, date and plac for investigation, in my opinion, death occ	e, and due to the caus curred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
thin 2 the 2 the 1	Medical	29b, Signature and title of certifier	and manner stated.	29c. License number		. Date signed (Month, Day, Year)
ř <sub>Š</sub> ř <sub>S</sub>		( P 2011)	mon mon	043121	1	0/15/07
(		30. Name and address of person who co	mpleted cause of death (Item 23a) (T	ype, Print)	a Table 1/1	LE MT 10866
JB5		NURUL CHOWDAL	IRY, MD; 15216	DINO DR. I BUR	ZIUNSVIL	10000
St	ate	30. Name and address of person who co  NURUL CHOWDHU  31. Date filed (Month, Day, Year)	32. Ratgistrar's Signature	Sparle		

Physician /Medical Examiner Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

funeral director, page 2 should After this n 24 hours after death.

In Funeral Director: Af intelly filled in by the fun

	Was case examiner? 1  Yes		
27.	Manner of	Death	

Natural 2 Accident 5 Pending investigation 3 ☐ Suicide 4 Homicide

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

completely

within 2.

31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 1 6

Hollywood mo 20636 Shah

Hospital or Attending

#### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene, 34597 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 1005 pm Beckett 10 2007 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) gomerset MD Cristield, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 218-20-5975 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 6. Sex Hours Days Months 1<u>Q</u>M 2□ F 83 Yrs. 11-10-24 Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes <del>Q</del> √ No CRISFIELD SOMERSET 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 201 HALL HWY 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S Armed Forces? 11. Marital Stetus Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Detes: 1 ☐ Yes 2XXXNo Specify Specify:BLACK 16b. Kind of Business/Industry 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) HALLS FAMILY RESTAURANT LABORER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)

HATTIE COLLINS

106 MAPLE CYT. SNOW HILL MD 21863

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

10-12-07

DENNIE SMITH FUNERAL HOME SALISBURY MD 21801

20c. Location - City or Town, State

SNOW HILL MD

Hall Highway Cristild, mo 21817

917 W. ISABELLA ST.

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23a or 28a-f ehow any injury or other traumatic event, if Medical Exercites must be routined at DICE. Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

10a, State

ISAAC BECKETT

PEARL PURNELL

20a. Method of Disposition

19a. Informant's Name/Relationship (Type, Print)

21. Signature of Funeral Service Licensee

NIECE

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Funeral Director

Be Completed by

**Funeral** 

Director

	23a. Part : Enter the disease, or compleshock, or heart wilure. List only o	lications that caused the deane cause on each line.	th. Do not enter the m	ode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death	
ysician Medical aminer	Immediate Cause (Final disease or condition resulting in death)	eDue to (	ASCVI		_	1	
ettending physician end for use as the bunel-transit . cian/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequence of				
I by the ettending physicic eteched for use es the bu Physician/Medical	Part II. Other significant conditions co	dntributing to death but not res	sulting in the underlying	cause given in Pert I.	23b. Did tobacco use co 1 ☐ Yes 2 ☐ No	ntribute to the cause of death?	
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettendin completely filled in by the funeral director, page 2 should be deteched for use completely filled in by the funeral director, page 2 should be deteched for use Medical Certification: To Be Completed by Physician/N					24a. Was an autopsy perlormed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No	
r, pag				OS Place of De	1 Li Yes 2 No	1 Li Yes 2 Li No	
i certifi director	25. Was case referred to medical examiner?	26. Place of Death (Check only one)  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify,					
th. : After this e funeral o	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur		
is after death.  al Director: After the din by the funerated in by the funerated in the fun	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fact	ory, office	28f. Location (Street and Numb City or Town, Stete)	ber or Rural Route Number,	
n 24 hours Ne Funeral pletely filled edical C	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	rsician: To the best of my known in the basis of examinating and manner stated.	owledge, death occurre ation end/or investigati	ed at the time, date and plac on, in my opinion, death occ	e, and due to the cause(s) and murred at the time, date and place,	anner as stated. and due to the cause(s)	
To the comple	29b. Signature end title of certifier	nter.	1	29c. License number  D 48098	,	ed (Month, Dey, Year) 9/2007 "	

20b. Place of Disposition (Name of cemetery, crematory or other place,

SHILOH UMC SNOW HILL MD

22. Name end Address of Fecility

DHMH 16 Rev 6/95

State Registrar

31. Dete filed (Mar

bunatha

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend its mid-operar das a 20 be per of the of the parady mass 22 10 - 29 - 07 vt Certificate of Death 2. Date of Death Arlene H. Baker Year Day

Physician
/Medical
Examiner

**Funeral** 

Director Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" --- any injury or other traumatic exercises.

> **Physician** /Medical **Examiner**

physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed for use cate has been signed page 2 should be del funeral director, this After t 24 hours after death. filled in by

Division or Vital Records, P.O. Box 68760,

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) ARLENCH. BAKER 10 21:47 2007 07 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Moin GENERAL OLNEY, MD MUNTGOMERY montaumere If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 F Bladen 245-50- 3957 1934 07-11-Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Elizabethtown Bladen Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number McCloud Street 2 8392 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Completed by Specify: Black 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Service Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be è Abram Alberta Graham Ita I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Columbia Gai Path Starburn MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Wilmington, NC 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 10-14-07 4 □ Donation 5 □ Other (Specify) Luneval Hone 21. Signature of Funeral Service Licensee — Douglas 22. Name and Address of Facility Jordan Funeral Home + Crematorium 901 So. Bit Street Wilmington, 28401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Days POST- OBSTRUCTIVE PUEUMONIA Due to (or as a consequence of): montres NAG CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 24b. Were autopsỳ findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou

To the Fune

completely fi (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie HOO65661 10/8/07 D.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1810, PRINCE PITICIP DR. OLNCY, MO Deborah Ster, Du

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT

29

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

teven roune	y Oc	1- For State Registrar	te of Maryland / Def C	ertificate of		eniai myg	Reg. I	No. 200	7 34599
Physic		1. Decedent's Name (First, Middle,	,				Date of Death		3. Time of Death
∕ledical Exar ⊶	nine	occven modney			h Cit. Tour and again		Month Da October 20, 2		1334 hrs
		4a. Facility Name (if not institution, Washington County Hos			b. City, Town, or Location Hagerstown	on of Death		4c. County of Death Washington	
Funera	ai			s. last birthday)	If Under 1 Year If U	Inder 24Hrs.	B. Date of Birth (N	MM/DD/YYYY) g. Bir	
Directo		187-48-4353 Usual Residence of Decedent	1 X M 2 F	49 Yrs.	Months Days Ho	ours Min.	04/04/	1958 Foreig	gn Juntry) PA
any		10a. State 10b. County	10c. C	ity, Town or Locati	on				10d. Inside City Limits
Aaryland	ا ال <u>د</u>	PA Frankl	in	Chambers	burg				1 X Yes 2 No
Maryla	Director	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·		10f. Zip Code		10g.	Citizen of What Cou	ntry?
th the					172			USA	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she	Funeral	11. Marital Status 1 Never Married 2 Marr	1 Yes 2 X No	lf Y	s Decedent of Hispanic ( es, specify Cuban, Mexic	can, Puerto Rio		White, etc.	ican Indian, Black,
s after ral",	2	3 Widowed 4 X Divon	ced If Yes, Give Year or Dates:		Yes 2 X No spec	·	la de la constante de la const	Specify: Wh	ite
2 hour	Completed	15. Decedent's Education (Specific Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. Deceden during mo	t's Usual Occupation (Gi ost of working life. DO N			oremost I	
21215-0036 uld be filed within 7 Mental Hygiene.	Completed	12	,	Fork1	ift Operato	r			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Important: If item 27 is marked other than			ast)		<u>-</u>		irst, Middle, Mai	den Surname)	
121 d be fi ental	other traumatic event,								
D 2 should and M	E S	19a. Informant's Name/Relationship Herbert E. Coy/F		- 7					1.7
Baltimore, MD Permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is		20a. Method of Disposition			riar Lane,			0c. Location - City or	
Baltimore, permit. Pages la Department of He Important: If ite	l el	1 X Burial 2 Cremation		crematory or oth	' - '				
Itir iit. Pa artmer ortani	<u> </u>	4 Donation 5 Other Special 21. Signature of Funeral Service Li		ring Hil	1 Cemetery ame and Address of Fac	110/26	Davis E	Shippensbu	irg, PA
Ba Perm Depz Imp	run function of the state of th	T.O. /			525 Bradbur				
Physicia		23a Part I. Enter the disease, or co failure. List only one cause or	omplications that caused the dea						Approximate Interval Between Onset and
/Medica	_	Immediate Cause (Final disease	a. Head Injuries						Death
		or condition resulting in death)	Due to (or as a consequence	e of):					
	à	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	e of):					
1	nsit Examiner	cause. Enter Underlying Cause	C	f\-					
M = =			Due to (or as a consequence d.	e or):					
760, cate be executed physician and	Medical Ev	UNPENDED	AMENDED						
60, cate be	ଥ   ≥	IF FEMALE:	23c. If yes, outcome of pr	regnancy				23d. Date of deliver	у
687 certific	Tor use as the	23b. Was decedent pregnant in the past 12 months?	1 Live birth  4 Pregnant at time of	doub -		topic pregnanc	у	Month	Day Year
Box 687 ne death certific		1 Yes 2 No 9 Unkno	7	death 5 Ot	ner (Specify)				
at the c	ତ୍ଥା 🏻	Part II. Other significant condition	ns contributing to death but no	ot resulting in the u	nderlying cause given in	n Part I.	23e. Did toba	cco use contribute to	the cause of death?
, P.O.	43						1 Yes	2 <b>✓</b> No 3 Pro	bably 4 Unknown
rds v requ	Completed						24a. Was an autopsy		utopsy findings available completion of cause of
tal Reco	age 7						performe 1 ✓ Yes 2		
an: T	director, page				26.Place of Dea				
Division of Vital Records, lat or Attending Physician: The law requires after death.		1 Yes 2 No		ER/Outpatient	3 DOA Other			sidence 6 Othe	er:
of Vit ling Physic			28a. Date of Injury (Month, Day, Year) Oct 20, 2007	28b. Time of I 1257 hrs		_  S	8d. Describe hov ubject struck	vinjury occurred by tree	
ivisior or Attencafter death Director:	y me	Natural 5 Pendin  2 Accident Investig	gation			No No			
Divis	Cortification:	3 Suicide 6 Could	not be		et, factory, office building			eet and Number or R e) ad, Greencastle, I	ural Route Number, City
Cospita Hourn			(apada) Sirigle I		red at the time date and				
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending in the first or the Control of the Attending in the state of	Completely tilled in by the Medical Cortification	(Check only one) 2 Medical Exami	resician: To the best of my knowledge: iner: On the basis of examination						
To To		29b. Signature and title of certifier	and manner stated.		29c. License numl	ber	2	9d. Date signed (Mo	onth, Day, Year)
		Joesha	Jelp	Nin	O.C.M.E.			October 21, 200	)7
		30. Name and address of person w	no completed cause of teath (II	tem 23a)					
10		Tasha Greenberg MD.	Assistant Medical Exa		Penn Street, Baltir	more, MD 2	21201		
	Stat	171 1 48 44 714	107 32. Registrar's Sign	ature	2				
	istra	u uci 2 2 20	101 photosis si	# 1					

DHMH 17 Rev 1/2001

State

Registrar

3311 TOLEDO TERRACE, HYATTSVILLE, MD. 20782

VAID, M.D.

2007

15

VIVEK C. 31. Date filed (Month, Day, Year)

OCT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2007 Derli Sun Chen October 8:20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🖾 F Months 376-94-6211 April 19,1957 Taiwan Director 50 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits show ns 23a or 28a-f shor must be notified at 1 □Yes 2 No Director North Potomac Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 12317 Mosel Terrace 20878 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Asian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) District Court Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hai-Chiao Tung Ming-Tao Sun ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12317 Mosel Terrace, North Potomac, Maryland 20878 Geider Chen/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 10/12/2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 10 East Deer Park Dr., Gaithersburg, MD. 20877 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic Colon Cancer Years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 Yes 2 No 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has rector, page 2 autopsy performed' 2 🔀 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No 2 uneral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No i Director: d in by the 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) D 42452 October 12, 2007 30. Name and address of person what completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Chitra Rajagopal,

31. Date filed (Month, Day, Year)

M.D.,

2007

Baistrar's Signature

18111 Prince Philip Dr., # 327, Olney, Maryland 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** CIRIACO ALONSO October 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hopkins Huspital Baltimore If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year 5/5/1958 9. Birthplace (State or Foreign Coun**Dominican** Republic 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 X M 2 □ F 49 579-92-7592 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County of Health and Mental Hygiene. Hem 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🙀 No Director MD Prince Georges BOwie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6304 GreenFell Court 20720 Dominican Republic Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerio Rican, etc.)

Dominican

1⊠Yes 2□No Specify: Republic Race - American Inc Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Caribbean Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5 + Elementary/Secondary (0-12) Finance Company Loan Consultant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Timothy Ciriaco Lucilla Regalado ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6304 Greenfell Court Bowie, MD 20720 Juanita Ciriaco/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or or 1 X Burial 2 ☐ Cremation 3 Removal from State Glenwood Cemetery 10/13/07 Washington, DC 4 □ Donation 5 □ Other (Specify) 420 H Street NE Wash DC 20002 21. Ignature of Juneral Service Licensee 22. Name and Address of Facility BK Henry Funeral Chapel 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** I month Cancer /Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (piscase or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-trar Due to (or as a consequence of): physician attending ph I for use as tl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐Unknown 1 TYes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b irector, page 2 si 24a. Was an 1□ Yes 2 X No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3□ DOA ို 1 Inpatient 2 ER/Outpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed P.O. Box 68760, Division or Vital Records, Hospital or Attending

Maryland 21215-0036

Baltimore,

State Registrar

the

2

DHMH 17 Rev 1/2001

29a. Certifier (Check only one)

Daniel

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Munoz,

OCT 1 6 2007

Johns Hupkins Hospital

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe Street Battimore Maryland

toher 9, 2007

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 26. AM **Physician** Crawford 10 7007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Maryland Media Ctr University of Baltmore 9. Birthplace (State or Foreign Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 14 1931 6 Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 1 F Washington, DC 75 Director 579-40-5001 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Bladensburg Prince George's MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20710 5999 Emerson Street # 719 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: White þ 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Manager 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mae Hefner George B. Johnson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4918 71st Avenue Hyattsville, Maryland 20784 Paczkowski/Daughter Shirley Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Bunal 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, Maryland permit. Page Department o Important; If any Injury or 10-13-2007 Riverdale Crematory J. B. Jenkins Funeral Home 22. Name and Address of Facility 21. Signature of Fundal Service Licensee 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 36 hrs Physician disease or condition resulting in death) memia /Medical Due to (or as a consequence of): Examiner 36 hrs SNOCK Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 36h15 that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed 2 HNo 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 2 No 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007 6 dress of person who completed cause of death (Item 23a) (Type, Print) Greene St. AShida Jetterson 32. Registrar's Signature Date filed (Month, Day, Year) State OCT 1 6 ZUUI Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.? 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6:20 AM 14 2007 October 0 D. Crews Myra /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Arunel Medical Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2√ Feb 10 1943 Washington, DC 64 579-56-1473 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10b. County 28a-f show 1 ☐ Yes 2 ☐ No Examiner must be notified Director Prince George's Bowie MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9 20716 USA 16010 Excalibur Road items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a any hijury or other traumatic event, the Medical Examiner must 1 once. by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Black Specify Specify: Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Government 2 yrs Research Editor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Geiger Gilbert Hunter ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4901 Olympia Avenue Beltsville, Maryland 20705 Dierdre Hardwick/Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Riverdale Crematory 10-20-2007 Riverdale, Maryland 4 □ Donation 5 □ Other (Specify) J. B. Jenkins Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 7474 Landover Road Landover, Maryland 20785 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 mon 1 Yes 2 No 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to Division or Vital Records, Completed by 3 Probably 4 Unknown 2No page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Anpatient . 3□ DOA 2 ER/Outpatient 1 ☐ Yes r this 27. Manner of Death 1 Natural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury After (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 4 Homicide

Certification: thours after death.

uneral Director: Ai ely filled in by the fu within 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29b. Signature and title of certifier 2 5 00057635 2 mo 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 2001 Wood 32. Registrar's Signature 31. Date filed (Month, Day, State

6 2007

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34605 1 - State Registrar Amended # 9 per FH, gc 10/16/07 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death CRAYTON Month **Physician** IONIA 1:10A M 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Clinton Pineview Nursing Home Prince Georges Social Security Number
 579–30–4978 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M. 2 🔀 F 83 Yrs. Director VΑ Ornage, Orange Usual Residence of Decedent 10c. City, Town or Location Camp Springs 10a. State MD 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Prince Georges XYes 2 □ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6210 Claridge Road 20748-2448 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify:Black 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Staffing Clerk Gov't 12th injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ould be f John White Virginia Burroughs Pages 1 and 2 should 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Mayo 6210 Claridge Rd Camp Springs, MD 20748-2448 if item 27 i Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 10/13/2007 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Rockville, MD Department of Important: If any injury or once. Parklawn Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility )X Bianchi 814 Upshur St NW Wash, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician renoscieno /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner -transit certificate be executed and Due to (or as a consequence of): attending physician a I for use as the burial-Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate has 2 🗷 No 1 Yes of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 28c. Injury at Work? Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred I or Attending Fafter death. Division Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by vitin 24 hours

in the Funeral Di 1 C'Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29c. License number

D 00 45365

10-10-07

AND P(0) fortunaliste mo 207(45) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 1:11 my

1/70

32. Registrar's S

sidasus, no

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

toper F. Collins		Si 1- For State Registrar	tate of Maryland /	Certificate of		wentai Hygiene	Reg. No.	200	
Physicia Jedical Exami		1. Decedent's Name (First, Midd Robert F. Co				2. Date of Month Octob	Death Day er 12, 200	Year	3. Time of Death 0132 hrs
		4a. Facility Name (if not institution Bon Secours Hospita			4b. City, Town, or Lo Baltimore City		4c.	County of Death	
Funeral Director		5. Social Security Number 025 50 4753	6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year  Months Days rs.	Hours Min.	of Birth(MM/0 18/195	Foreig	thplace (State or yn untry) MD
any		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Loc	ation		_		10d. Inside City Limits
Maryland 28a-f show d at once.	ţō	CT New H	aven	Southbury	10f. Zip Code		140- Citi-	zen of What Cou	1 Yes 2 X No
with the Maryland us 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 1284 Strongton	wn Rd.		06488		USZ		indy:
hours after death with the Maryland natural", or items 23a or 28a-f sh Examiner must be notified at once	Funeral	11. Marital Status  1 Never Married 2 X	12. Was Decedent			nic Origin? (Specify Yes Nexican, Puerto Rican, etc		14. Race - Amer White, etc.	ican Indian, Black,
fter dea			1 Yes 2 vorced If Yes, Give Year	X No 1	Yes 2X No	specify:		Specify: Whi	ite
hours a natural	ed by	15. Decedent's Education (Sp.		during	ent's Usual Occupation most of working life. D	(Give kind of work done O NOT use retired)	16b. K	(ind of Business/	Industry
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12 12	College (1-4 or 5		1 Manager		1	Hotel	
		17. Father's Name (First, Middle Robert F. Col.)		<u> </u>		Mother's Name (First, Mic A. Mary Mal		Surname)	
2121 tould be fill d Mental F s marked tic event,	To Be	19a. Informant's Name/Relation	ship (Type, Print )		ing Address (Street a	and Number or Rural Rout	e Number, Ci		e, Zip Code)
imore, MD 2121 Pages I and 2 should be fi nent of Health and Mental ant: If item 27 is marked or other traumatic event,		A. Mary Colling	ns/mother		Route 29 osition (Name of ceme	Columbia,		1045 Location - City o	r Town, State
Baltimore, permit. Pages I an Department of Heal Important: If iten injury or other tra		1 X Burial 2 Crematic		te Crematory or Lorraine	other place) Park Cem.	10/20/20	007 WX	odlawn,	MD
Baltimo permit. Page Department o Important: injury or oth		21. Signature of Funeral Service		22	. Name and Address o	fFacility Harry H.	. Witz	ke's Fan	nily FH Inc.
Physician		23a. Parl I. Enter the disease, of		14	LLZ Old Co	lumbia Pk.	+:	ott ('1ts	Approximate Interval Between Onset and
/Medical xaminer		failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	e a. Heroin and		xication				Death
		Sequentially list conditions,	Due to (or as a conse	equence or):			_		
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse	equence of):					
recuted and transit	Exar	events resulting in death) Last	Due to (or as a conse	equence of):					
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	dical	X UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 U	X AMENDED 2/12	perME,G87 8a-f, perME,C	3,11/19/07 3872,10/30/0	WS 7 TT			
8760 tificate I ng phys as the bu	ın/Me	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes, outcon	ne of pregnancy	Fetal death 3	Ectopic pregnancy	23	d. Date of delive Month	ry Day <b>Y</b> ear
Sox 6876 leath certificat e attending ph for use as the	sicia	past 12 months?  1 Yes 2 No 9 U	4 Pregnant at	time of death 5	Other (Specify)		_		
that the d ned by the detached	y Phy	Part II. Other significant cond		n but not resulting in th	e underlying cause giv	en in Part I. 23e.			the cause of death?
Is, P quires then signe and be d	ted by	\  ———				1 24a	Yes 2		obably 4  Unknown
cords, e law requir e has been s	Completed				-		autopsy performed? Yes 2 N	prior to death?	completion of cause of
Vital Rec ysician: The l his certificate l	Be Co	25. Was case referred to medic				f Death (Check only one)	res ZN	No 1 🗸	res Z No
f Vit Physici er this c	မ	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie	ent 2 ER/Outpatie		ther Nursing Home at Work? 28d, Des	5 Reside	ence 6 Oth	er:
Division of 'pital or Attending Phours after death.  reral Director: After tilled in by the funeral	Certification:	1 Natural 5 Pe	(Month, Day,Y estigation Fnd 10/1	ear)		s 2 X No unk		•	
Divisi  Divisi  spital or Att  hours after d  nneral Direct  y filled in by	rtifica	3 Suicide 6 X Co	uld not be	jury - At home, farm, si		or T	own, State)		Rural Route Number, City
Hospita 24 hours Funeral		29a. Certifier Certifying	Physician: To the best of m	OUSE y knowledge, death oc	curred at the time, date	and place, and due to th	e cause(s) ar	nd manner as sta	Itimore, MD
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Ex	aminer:On the basis of examiner stated.	mination and/or investi	gation, in my opinion, o	death occurred at the time	, date and pla	ace, and due to Date signed (M	the cause(s)
	Σ	29b. Signature and title of certi-	ner		O.C.M		- 1	tober 12, 200	
E.G.		30. Name and address of person	·			ND 6 155			
6	tate	Ana Rubio MD. As	ssistant Medical Exam	niner 111 Penr	Street, Baltimor	e, MD 21201			
S Regis		out med product pay, 1 gal	70 2001	10 10					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Ralph Cannon Crouch 07 /Medical 4b. City-Town, or Location of Death County of Death Facility Name (If not/institution, give street and number) Examiner enter lisburi 1CAMICO eninsula! If Under 1 Year | If Under 24 H Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Numb **Funeral** 1**⊠**M 2□F Months Days Hours June 30,1947 Maryland 60 216-48-5317 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 XYes 2 □ No notified Funeral Director Delmar Maryland Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code ms 23a or 2 must be n 21875 USA 800 East Chestnut St., Apt. 104 ural", or items 2 I Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examine ones. 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify. White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Rental Properties Landlord 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eunice Laverne Cannon ဂ္ Ralph Henry Crouch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5329 Sixty Foot Road, Parsonsburg, MD 21849 Bobby Elswick/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State Parsons Cemetery 10/12/2007 Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Zeller Funeral Home, 1212 Old Ocean City Road
P.O. Box 3171, Salisbury, MD 21802 21. Signature of Frineral Service Lilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 AXUD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director; After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed hypersi pidemia 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Yes 2□ No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 5 10 10 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

State Registrar 31. Date filed (N

DHMH 17 Rev 1/2001

100 E. Carroll St. Salisbury, Md. 21801

DHMH 17 Rev 1/2001

State

Registrar

Hospital

Ives Ton

2007

OCT 1 6

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 10:15P M Downs OCT. 10. 2007 Mildred Stephenson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
April 2, 1918 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2**X** F Director 89 Arkansas 429-82-8141 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States of America 20904 12433 Pretoria Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3√ Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Public Schools 12 should be filed w n and Mental Hygier is marked other ti permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertha Maddox Cecil Stephenson ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12433 Pretoria Drive; Silver Spring, MD 20901 Charles Stephen Downs - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/15/07 St. Charles, Arkansas Charles Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHines Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave; Silver Spring, MD 20904 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical lling dexan Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or Injury that initiated events resulting in death) Last Examiner certificate be executed as the burial-transi and Due to (or as a consequence of): attending physician for use as the buna P.O. Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant gonditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4X Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has autopsy performed? certificate 1∐ Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this funeral 28a. Date of Injury (Month, Day Year) after death.

| Director: After the in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: or Attending 1 ₺ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the I 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 0CT 1 5 2007

Nasreen Kango, MD



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nasreen Kango, MD 7701 Carroll Ave. Takoma Park, Md 20912

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11, 7:48 A.M 2007 J. Dowd Ellen October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chevy Chase Montgomery Manor Care of Chevy Chase If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F New York 90 24, 1917 Director 126-14-3072 Jan. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10h. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 □Yes 2 No Director Bethesda Maryland | Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number "natural", or items 23a or idical Exaπiner must be r 20814 4821 Montgomery Lane United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: Completed by 3 Widowed 4 □ Divorced White 16a Decedent's Usual Occupation 16h Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygh Important: if item 27 is marked any injury or other the one. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Timothy Patrick O'Shea Sullivan ၉ Agnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4821 Montgomery Lane, Bethesda, Maryland 20814 Patricia D. Reisin/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 1 K Burial 2 ☐ Cremation 3 ☐Removal from State Gate of Heaven Cem. 10/15/2007 4 □ Donation 5 □ Other (Specify) Silver Spring, MD. 22. Name and Address of Facility DeVol Funeral Home nature of Funeral Service L 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Preumonia disease or condition resulting in death) /Medical Due to ( r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed Exami burial-trar Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical the death certificate attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 9□Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No has e 2 autopsy perform Yes 2 page certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 2 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 1 Natural 5 Pending investigation thin 24 hours after deau...

o the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 2 D0054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14702 Cherry Leaf terrace Silversoring HMZaga Bhog Sunitha avilli 31. Date filed (Month, Day, Year) 5 1 2007 OCT Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Robert D. Dix 13 2007 4:00p October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick 5860 Genesis Lane Unit 413 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 X M 2 □ F Yrs March 22,1928 Pennsylvania 79 Director 577-30-1274 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location show 10b. County r 28a-f show notified at 1 ☐ Yes 2 PNo Director Frederick Frederick Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or 3 iner must be n 21703 United States 5860 Genesis Lane Unit 413 Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? "natural", or item Black, White, etc. 1 TYes 2 No If Yes, Give Year or Dates: 1944-70 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Navy Communiactions Officer 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be or other traumatic ev Gertrude Barney ပ Frank A. Dix 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lewis Drive, Millsboro, Delaware 19967 Ronald Robinson/ Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If iter any injury or oth once. 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Stauffer Crematory Inc.10/16/07 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown 21. Signature of Emeral Service Licenses Home P. A. Pike, Frederick, Maryland 21702 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mycoordnal 1 Do CHID /Medical to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4 Pregnant at time of death 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No +bmla Hox 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Hypertansien autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) ၉ 1 ☐ Yes 27. Mapher of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: A 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours aft ie **Funeral DI** iletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation in my online. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sign 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Thomas

6

2007

Friderick ND 21802

08<sup>Day</sup> Month 10 **Physician** 2007 <u>John Durana</u> /Medical Edward 6.00a 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert 9101 Paulyn Drive Owings If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 91 02/10/1916 Pennsylvania Director 207-09-3053 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 Tyyes 2 □ No Examiner must be notified Director Maryland Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò U.S.A. 9101 Paulyn Drive items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 1 Q 4 4 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mertal Hydjene.
Department of Health and Mertal Hydjene.
Important: If item 27 is marked other than "natural", or iten file mortant if item 27 is marked other than "any Injury or other traumatic event, the Medical Examiner any Injury or other traumatic event, the Medical Examiner. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No White Baltimore, Maryland 21215-0036 Year or Dates: 1944 — Specify. Specify. Widowed 4 □ Divorced 1946 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Government Printing Elementary/Secondary (0-12) College (1-4or 5+) Printer Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theresia Kalarik Jon Durana ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9101 Paulyn Drive, Owings, Maryland Joan Ulrick/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Sacred Heart XX Burial 2 ☐ Cremation 3 ☐ Removal from State Bowie, Maryland 4 Donation 5 Other (Specify) 10/11/2007 Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Colon Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached? 1 □ Ves 2 □ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Hypertension, chronic renal failure, prostate cancer, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an anemia autopsy death? 1 ☐ Yes After this certificate 2□ No 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Frentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ara V. Muscoril MD 10/9/2007 D46992 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1438 Defense Highway, Gambrills, Md. 21054 Tara T. Muscovich, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar OCT 1 2 2007 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

1. Decedent's Name (First, Middle, Last)

Reg. No.

2. Date of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 10:20 PM Frank Miller Eccard October 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital ocial Security Number 6. Sex 7. Age ( Washington 9. Birthplace (S Hagerstown
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, April 3 (State or Foreign Age (In yrs. last birthday) <sup>Year)</sup> 1925 **Funeral** 1**X** M 2□ F 82 Yrs Maryland 220-26-5408 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 □ Yes 2 X No Director Frederick Md. Smithsburg 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 14614 Stottlemyer Rd. 21783 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 Nes 2 No If Yes, Give Year or Dates: 41 -46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**]** No Specify: <u>ک</u> Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Correctional Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Noah Eccard Amy Alice Miller ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roland N. Eccard (Son) 222 Mountain Terrace Myersville, Md. 21773 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) Oct. 26, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garfield, Md. 4 ☐ Donation 5 ☐ Other (Specify) Methodist Church Cem 22. Name and Address of Facility 2007 21. Signature of Funeral Service Licensee 12525 Bradbury Ave. M01414 J.L. Davis Funeral Home Smithsburg, Md. 21783 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MEDMONIA Physician 100 day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) g physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy perforn 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 🗆 No neral Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29c. License number D 2 83 65 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10-23-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) niell threel- Hagestonin 1912 21740 ude 368

Registrar DHMH 17 Rev 1/2001

10

State

laul 31. Date filed (Month, Day,

> 9 2007

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 2007

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day October 11, 2007 **Physician** Enid Lowe Enge1 1:55pM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery Potomac Valley Nursing & Wellness Ctr. Rockville If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) China 8. Date of Birth (Month, Day, Year) June 17, 1921 **Funeral** 1□M 21☐F Months Days Hours 410-30-5274 86 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 20902 1501 Gridley Lane USA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 3€ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white Completed by 3 Nidowed 4 □ Divorced "naturel" 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be fillet.
Department of Health and Mental Hygin Important: if tiem 27 is marked any injury or other \*\*\* marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clifford Jackson Lowe Julia Ella Martin 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1501 Gridley Lane, Silver Spring, MD 20902 Donald S. Engel/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Oct. 30, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'l Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Arlington, Virginia 21. Signature of Funeral Service Licensee Francis Address Collins Funeral Home Inc. Solve 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed physicien and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deal
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autoosy performed? 1 Yes 1 Yes 2 No 2 18 No To the Hospital or Attending Physician: tor: After this certific the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 Yes 2 No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00062435 Medic Center Dr. Rockville, MD 20850 30. Name and address of person who completed cause of death (Item 23a) (Type-Print) 9715 SAYED ELSAYYAU 32 degistrar's Signature 31. Date filed (Month, Day, Year) State 15 Registrar

			1 - For State Registrar	State	of Ma	ryland / Dep <i>Ce</i>	artment of H rtificate of I				ene g. No 2007	34615
26.7 1977	Physici	an	1. Decedent's Name (First, Middle,	_					Mo		Day Year	3. Time of Death
	/Medic Examir	cal	4a. Facility Name (If not institution,	E S s		/(	4b. City, Town, or	r Location	<del></del>	TOBE	4c. County of Death	7:0204
	Examil	ier	Washington Adv			tal	Takoma				Montgome	erv
1	Funeral		5. Social Security Number NONE	6. Sex 1 □ M 2 🛣 F	7. Age 60	(In yrs. last birthday)	If Under 1 Year Months Days	If Under Hours	Min. (Mo	e of Birth onth, Day,	Year) 9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent	1 M 2 Q	00	Yrs.			Augu	ıst 1.	5 1947 Came	eroon
	yland Jow		10a. State 10b. County	<del></del>		10c. City, Town or Lo	ocation					10d. Inside City Limits
	e Mar e-fs!	ctor	MD Prince	George'	s	Beltsv	ille					12∑Yes 2 No
	or 28	Funeral Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of What Cou	ntry?
	s 23a	sral	12103 Benjamin				20705				Cameroon	1-1
	ter de	Fune	11. Maritał Status 1 ☐ Never Married 2 ☑ Marrie	12. Was Ded Armed F	orces?	er in U.S.	Was Decedent of Hi If Yes, specify Cuba	ispanic Ori in, Mexicar	igin? (Specify Ye n, Puerto Rican, i	etc.)	14. Race - Ameri Black, White,	
99	al', or	by	3 Widowed 4 Divorced	If Yes, G Year or I	ve		1 ☐ Yes 2 ☑ No	Specify:			Specify: Bla	ack
5	filed within 72 hours after deeth with the Maryland Hygiene. uther then "natural", or Items 23a or 28e-f show int, the Madical Excitting man by notified at	Completed	15. Decedent' (Specify only highest	s Education		16a. Dece	dent's Usual Occupa	ation	at of working	1	6b. Kind of Business/in	dustry
121	within ine. ihen	mpl	Elementary/Secondary (0-12)	College	1-4or 5+		kind of work done o DO NOT use retired	1)				
Ω Φ	filed v Hygie ther t		17. Father's Name (First, Middle, L	4 yr	5	Past	cor	18. Mothe	er's Name (First,		Private	
an	id be lental ked o	To Be	Jeremieh Nyiang						eborah		anghabei	
Maryland 21215-0036	shou and M s mar	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address (Street a				City or Town, State, Zip	Code)
Σ.	and 2 ealth n 27 i		Charles Essem/	Son				n Str	eet Belt	svil	le,Maryland	i 20705
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28e-f show eny Injury or other treumatic event, the Martical Examinar must be notified at ODEs.		20a. Method of Disposition 1   ■ Burial 2   □ Cremation	3 ⊠Removal from	State	20b. Place of Dispo cemetery, crea	sition (Name of matory or other plac	e)	Date	20	0c. Location - City or To	own, State
<u>=</u>	it. Partmen rtant: njury		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L	The second second		Family P	lot	1	0-31-20	07 N	gie, Camero	on
Ba	Depa Depa Impo eny l		21. Schature of Funeral Service L								kins Funera Maryland	
			23a. Part1. Enter the disease, or o	complications that	caused th	ne death. Do not en						Approximate
	Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition	^		L FAI	INRE					Interval Between Onset and Death
1	/Medical		resulting in death)	Due to	(or as a	consequence of):						
€.	Examiner	_	Sequentially list conditions,	h R	ES 1	PIRAT	ory	FA	ILURI	$\epsilon_{-}$		
	led sit	nlne	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a	consequence of):	- 1/01	OF	01		2 ~	
	execut n and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a	EST/V)	= HEA	151	FAT	C 00	() <u>-</u>	
8760	rate be executed oblysicien and the burial-transit			a Co	ROI	NARY	ARTER	24	DISE	ASE		
Ó	The law requires that the death certificate be executed to has been signed by the ettending physicien and vage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:									
Вох	leath certifica ettending pt I for use as t	lan/I	23b. Was decedent pregnant in the past 12 months?		oirth 2	Fetal death 3	Ectopic pregnancy				23d. Date of delive	ery Day Year
	he de the e	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9□Unkr		ne of death 5	Other (specify)				1001141	Day Tou.
о. О	res that the de igned by the c be detached t		Part II. Other significant condition	s contributing to	eath but	not resulting in the u	nderlying cause give	en in Part I.	. 23	e. Did toba	acco use contribute to t	he cause of death?
Vital Records,	w requires been sign should be	ed by	DIABETES							1 🗌 Yes	2 No 3 Prot	oably 4 Shiknown
ဝ္ပ	law re	Completed							24:	a. Was an	24b. Were auto	ppsy findings available
Ĭ		Com							1	autopsy perform Yes 2		mptetion of cause of
/Ita	clan: ertific actor,	Be (	25. Was case referred to medical examiner?					-	of Death (Chec	k only one,	)	
0	≥ .e. b	1	1 ☐ Yes 2 No  27. Manner of Death	Hospital: 1 28a. Date	Inpatient	2 ER/Outpatier		4 ∐ Nu			ice 6 ☐Other (Specia	(y)
Division of	tending Pt leath. tor: After th the funeral	tlon	1 Natural 5 Pending 2 Accident investiga	(Mor	th, Day	(ear) Injury	Work	∕aτ ⟨? Yes 2 ∐ I		SCIDO NOV	v intury occurred	
VISI	or Attendation deating Director:	Ifica	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Plac	of Injury	- At home, farm, str			28f. Loc		et and Number or Rura	al Route Number,
ā		Certification:	4  Homicide determin	build	ing, etc.	(Specify)			City	or Town,	State)	
,	To the Hospital or A within 24 hours after after to the Funeral Directompletely filled in by	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To th	best of	my knowledge, deat	n occurred at the tim	ne, date an	d place, and due	to the cau	use(s) and manner as s te and place, and due to	tated.
	To the Mithin 2	Med	one) 29b. Signature and title of certifier	and mar	ner state	d.	29c. License				d. Date signed (Month,	
	FEF)S		1/1-	-) n	15		Da	05	7649	1	15 260	10 0
(	0		30. Name and address of person w	ho completed cau	se of dea	th (Item 23a) (Type	Print)		.01/	0	しつのちじん	10,2007
	El .		30. Name and address of person w BR YAN M. STE  31. Date filed (Month, Day, Year)  OCT 1 6 2	NBERC	m	> 300	1 Hospi	TAL	Dr. C	HEV	ERLY 1	n D 20789
	Sta	te	31. Date filed (Month, Day, Year)	0007 32	Registrar'	s Signature	. K.		,	•	1	
	Registr	ar	UU1 1 0 2	.001	em	D. Up	MEL					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 17

		•	For State Ragistrar	State	of Marylar	nd / Depa <i>Cei</i>	rtment c	of He	ealth a Death	ınd M		ienę g. No.	2007	34616
			Decedent's Name (First, Middle, La	ist)							2. Date of Deat Month	h Day	Year	3. Time of Death
K	Physici /Medic		Irene Ellen Ever	sman							Octobe			10:05P M
Star Star	Examin	_	4a. Facility Name (If not institution, given	e street and no	um <i>ber)</i>		4b. City, Tov	vn, or l	Location o	f Death		4c. 0	County of Death	1
家		e#-	Manokin Manor		1		Princ				0. Data of Bigh		merset	alone (State of Foreign
10	Funeral Director			Sex 1 □ M 2 🗓 F	7. Age (In yrs. 98			ays	Hours	Min.	8. Date of Birth (Month, Day, Oct. 11,	Year)	Cou	place (State or Foreign intry) yland
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c Cir	ty, Town or Lo	cation							10d. Inside City Limits
)	sho	5						~~						1 ☐ Yes 2X No
7	the N	Director	Maryland Wicomic	J		Mardela	10f. Zip Co				1	0g. Citiz	en of What Cou	untry?
)	with		23821 Ocean Gate	wav				218	337				USA	
)	deeth ms 2;	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.				gin? (Spe	cify Yes or No- Rican, etc.)	1	4. Race - Amer	
36	gos 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Exacult at Envalue inclined at	by Fur	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	Armed F 1 Tes If Yes, G Year or I	2 ፟X No iive	1	r Yes, specify 1 ☐ Yes 2 <mark>X</mark>		Specify:	, Pueno r	tican, etc.)		Black, White Specify:	hite
21215-0036	2 hou	ted	15. Decedent's E			16a. Dece	lent's Usual O kind of work o	ccupa	tion	of working		16b. Kin	nd of Business/I	ndustry
215	thin 7	Completed	(Specify only highest gr Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use n	etired)	unng mosi	OF WOLKIE	ig			
7	or th	Con	12			Homen	naker						Own Ho	me
Maryland	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las.								(First, Middle, M			
<u>Y</u> a	ould Men Marke Marke	ဥ	Oscar Truitt Smi			405 44-18					Ellen S			in Code!
Mar	12 sh h and 7 ts n traun		19a. Informant's Name/Relationship Anita Corbett/Dat	•			•				ardela S	•		
e,	1 and Healt em 2		20a. Method of Disposition	agnicei	20b. I	Place of Dispo	sition (Name	of					cation - City or	
Por	ages nt of t: ff it f or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		n State	cemetery, crer anuel UM				0/20	/2007	Mard	lola Car	ings, MD
Baltimore,	permit. Pages 1 and Depertment of Heali Important: if item 2 any injury or other ance.		21. Signature of Funeral Service Lice		West 1		-							MD 21802
	70 E 4 0	-/	22a. Part. Enter the disease, or con	119									sbury,	MD 21802 Approximate
		4	Landrick, or heart failure. List only	one cause on	each line.	III. DO NOT BIN	91 (119 INOG6 O	i uyaig	, 30011 03	cardiac o	nospilatory am	531,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	_a	,		swy							loyears
H	Examiner			Due to	o (or as a consec	quence ot):								
		e	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a consec	quence of):								
	uted d ansit	든	cause. Enter Underlying Cause (Disease or injury that initiated events											
Ć,	cate be executed physicien and the burial-transit	Exa	resulting in death) Last	Due to	o (or as a consec	quence of):								
8760,	ite be iysicie ne bu	cal		d										
9	ng ph	Med	IF FEMALE:											
. Box	Attending Physician: The law requires that the death certific rideath. •ctor: Atter this certificate has been signed by the attending port the funeral director, page 2 should be detached for use as	by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months?	1☐Live	utcome of pregn birth 2 Peta gnant at time of c	aideath 3[	Ectopic pregr Other (speci					2	3d. Date of deli Month	very Day Year
P.O.	at the	hys	9 Unknown								T			the server of death?
Ś	ires tha signed d be del		Part II. Other significant conditions	contributing to	death but not res	sulting in the u	nderlying caus	e give	n in Part I.		238. Dia toi		1	the cause of death?
Vital Record	w requir been si should	Completed									24a. Was a	n	24b. Were au	topsy findings available
Rec	ne tav e has ge 2	μ									autops	ned?	prior to death?	completion of cause of
ā	n: T/	e Co	25. Was case referred to medical						26 Place	of Dogsth	(Check only on	2 PNo	1 ∐ Yes	2 No
₹	sicia s certi	To Be	examiner?	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA	Othe	. /		ne 5 Reside		Other (Spec	cify)
ō	g Phy er this		27. Manper of Death	28a. Date	e of Injury onth, Day Year)	28b. Time o		Injury			8d. Describe ho			
<u>o</u>	nding ath. r: Aft	atio	1√ZNatural 5 ☐ Pending 2 ☐ Accident investigation		min, Day 16ai)	Inquity	М		res 2□	No				
Division of	or Atterder de lirecto	Certification:	3 Surcide 6 Could not l 4 Homicide determined	288. Plac	ce of Injury - At h ding, etc. (Speci	nome, farm, st	eet, factory, of	ffice		2	28f. Location (Si City or Town			ral Route Number,
	To the Hospital or Attending Physician: The lawinin 24 hours efter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Ce	29a. Certifier 1 Certifying P	hysician: To the	ne best of my knobasis of examina	owledge, deat	n occurred at t	he tim	e, date an	d place, a	and due to the c	ause(s) ate and	and manner as place, and due	stated. to the cause(s)
	To the H within 24 To the Fi complete	Medi	one)		nner stated.				number				e signed (Monti	
	To Too	~	29b. Signature and title of certifier				,			G				
			men	DR. US		TSAN THE		VO	5735	7	(	ichoh	w 16/2	100/
			30. Name and address of person who		. 37			90	4					
43	Sta	te.	1415 - 5 - DIVISIO 31. Date filed (Month, Day, Year)	32.	, S AUSS Register's Sign	ature	Model		1					
	Registr		OCT 1	7 2007	A Distance	J.K	Mode	0						

I rene E. EVERSMAN 212-10-2661

State of Maryland / Department of Health and Mental Hygien $2\,00\,7$ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month EDWARDS, **Physician** SR. October 11, 1:00 P M DONALD 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick 5004 Court Jefferson Jane If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours Mary Land 64 Yrs 220-38-1016 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County r than "natural", or itams 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Jefferson Maryland Frederick Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code United States 21755 5004 Jane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Building/Construction Carpenter-Foreman 12 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If itam 27 is marked oth any Injury or othar traumatic evant <u>once</u>. Mary Edwards Ralph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5004 Jane Court / Jefferson, Maryland 21755 Joan Edwards / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 10/14/2007 Timonium, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike/ Frederick, MD 21702 23a. Part. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock/or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non-Hodgekin's Year **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown been signed by t should be detach 23e. Did tobacco use coptribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No this certificate 1 Yes 2 19 No Hospital or Attanding Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ■ Residence 6 Other (Specify) 2 1 No Certification: To 1 Yes 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of After 1 Natural 1 ☐ Yes 2 ☐ No investigation after death Diractor: / 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funaral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce 30. Name and address who completed cause of death (Item 23a) (Typg, Print) 240 ( W. Ne Vedere que, BAlt. 4021213 1+0 06 A 111) 31. Date filed (Moch egistrar's Signature 2007

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar Item	State of Maryla s 23a, PtI, 2	ind / Depa ,27,28	artment of l	Health and	Mental Hyg .0/26/07ф	iene hb.20	7	3461	8
			Decedent's Name (First, Middle, Last)					2. Date of Deal Month		Year	3. Time of Deat	th
	Physici /Medi		Catherine Teresa	Esmond				October		7	1405	М
	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of Dea	th	4c. County			
			Harford Memorial				de Grace		Harf		(Ctata Fa-	
	Funeral		5. Social Security Number 6. Sex 1□	M 22XF 7. Age (In yr	s. last birthday) Yrs.	If Under 1 Year Months Days			Year) 958	Mary 1	ice (State or For and	eign
	Director		Usuat Residence of Decedent	47				Journe of	,,,,,			
	yland		10a. State 10b. County	10c. 6	City, Town or Lo	cation				10	d. Inside City Lir	
	a-f	cto	MD Harford	Há	avre de	Grace					1 □ Yes 2 🔀	INO
	ith th	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V		y?	
	ath w	rai	800 Country Club			2107		2Na	U.S.A.	e - America	n Indian	
	er de Item	ë	11. Marital Status  1 XNever Married 2 Married	<ol> <li>Was Decedent Ever in Armed Forces?</li> <li>1 ☐ Yes 2 X No</li> </ol>	U.S. 13.	Was Decedent of f Yes, specify Cub	pan, Mexican, Pue	Specify Yes or No- to Rican, etc.)		k, White, el		
39	irs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify	Whi	ite	
9	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28a-f show fre Medical Examinar must be notified at	ted	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occu	pation during most of wo		16b. Kind of Bu	isiness/Indu	ıstry	
2	ithin 1990.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)	9		4.		
2	led w tygier her th		17. Father's Name (First, Middle, Last)		Disa	ptea	18 Mother's Na	me (First, Middle,	Depend			
anc	ntal H	Be	Dr. William Geo	rae Esmond				Marie Wea		-		
Maryland 21215-0036	should Me Me mark matik	2	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Stree	t and Number or R	ural Route Number	, City or Town,	State, Zip (	Code)	
<b>S</b>	nd 2 :		Ella Esmond (Moth	er)		Country (		Havre de			21078	
Je,	of Heel		20a. Method of Disposition	206	. Place of Dispo	sition (Name of natory or other pla	ace)	Date	20c. Location -	City or Tow	n, State	
Ē	Page nent c		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	movalitoni State		on Cemete		′11/07 I	Darling	ton, 1	/ID	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Importants if item 27 is marked other then "naturel", or items 23a or 28a-f ehow eny Injury or other traumatic event, it a Medical Examinar must be notified at once.		21. Signature of Funeral Service Fense	the Valent	woode		ing-Cargo deen, Mar	Funeral		99 <sup>A</sup> •		
Y	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ati his that caused by dee cause on each line.  Due to (or as a cons	H	er the mode of dy	ing, such as cardia	>		-	Approximate Interval Betweer Onset and Death	
8760,	rate be executed by sicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons		ous a c	CENTRIATIO	I DEM	2.1173 DICAL EXAMINER	3		
P.O. Box 68	Attending Physicien: The law requires that the death certificate in death.  ector: After this certificate hes been signed by the attending phys by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Sc. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3	Ectopic pregnand Other (specify)	Э		23d. Dat Mo	e of deliver	y Day Year	
o, G	s that gned t	oy P	Part II. Other significant conditions con	ributing to death but not r	esulting in the u	nderlying cause g	ven in Part I.				cause of death	
ğ	equire sen si ould?	ted	Cerebral pal	sy				1 U Y	9S 2 No	3 ☐ Proba	bly 4 □Unkn	own
Division of Vital Records,	The law rate hes be page 2 sh	Comple	Aspiration					24a. Was a autops perform	ned?	Were autop prior to com death? I ☐ Yes :	sy findings avail ipletion of cause 2□ No	able of
/ita	clan: ertific ector.	Be	25. Was case referred to medical examiner?	a acitali				eath (Check only or	e)			
5	Physi this c	2	1 X Yes 2 X No. 27. Manner of Death		☐ ER/Outpatier 28b. Time o	IL 3 DOA		Home 5 Reside			1	
L C	ding l	tion	— <del>1 Natur</del> al 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 01/03/2007	3:16	Wo	ork? ⊒Yes 2. TXTNo	Subject	passen	ger i	n a min	i-
S	deat deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - Al	home, farm, st	-		van that 28t. Location (S	root and Numb	or or Quest	Route Number	ar.
چ	atter Dire d in b	Certification:	4 Homicide	Roadway	cify)			Mt. Roya	Ro	.Aber	2 near deen MD	
•	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	edicai C		ician: To the best of my ker: On the basis of examinand manner stated.				e, and due to the c	ause(s) and ma	nner as sta	ited.	
	To the within 2 To the complet	Me	29b. Signature and title of certifier			1	ise number		9d. Date signe			
)			(1/5)	91D		Do	05356	8 c	etober	-7,.	2007	7
	4		30. Name and address of person who co	poleted cause of death (I	tem 23a) (Type,	Print) 50	1 Sou	th UN	ion Au	Q		
	1		31. Date lifed (Month, Day, Year)	hompsow 32. Registrar's Sig		210	078 Ha	vre de C	Jace .	111	)	
	Sta Regista		OCT 2 6 2007	Sz. Togistiai s Sig	Break	2						

DHMH 17 Rev 1/2001

10/1/01

Esmond, Catherine

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** October 0 05:48 Felmey 2007 Alvin Eugene /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner South River Health & Reb. Center Anne Arundel Edgewater Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 87 Pennsylvania 193-12-8038 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 □Yes 2 □No Ellicott City Director Maryland | Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21043 8238 Glenmar Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. "natural", or Iten dical Examiner filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No altimore, Maryland 21215-0036 Specify: Specify. White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical. Elementary/Secondary (0-12) College (1-4or 5+) Automobile Auto Worker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Estella Hendricks Palmer Felmev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8238 Glenmar Road, Ellicott City, Maryland 21043 Mark E. Felmey/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 10/13/2007 Baltimore, Maryland New Cathedral Cemetery 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 2973 Solomons Island Road, Edgewater, Maryland 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician a Box 68760, Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the linector, page 2 s autopsy 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) director, Be Hospital: 2 ER/Outpatient 3□ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient Certification: To this 28a. Date of Injury 27. Manner of Death 1 ☐ Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year, Iniury 5 Pending investigation M 1 ☐ Yes 2 ☐ No ours after death.
neral Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide within 24 hours at To the Funeral C completely filled i 1 Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number 3x1 30. Name and address of pe on who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 1 2 2007 Registrar

			ricase	State of Maryla				•	-	
			1 - For State Registrar	State of Maryla		rtificate of			200	7 34621
	ų.		Decedent's Name (First, Middle, Last	)				2. Date of Death	g. 11042 O O	3. Time of Death
	Physici /Medi		Francis	L. Grum	bine	)		Month -	వీ(o - వీరి	07 0615 AM
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death	al Adan	49 County of D	
				n's Choi	ce	3900	baker Lir	Cle n	nD	trederick
	Funeral Director		5. Social Security Number 6. Se	X 7. Age (In yrs	i. last birthday) <b>2</b> ( Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		1931	Birthplace (State or Foreign Country)  MD
			Usual Residence of Decedent		30			04/07/	1921	TID
	how	_	10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits
	Ba-f e	cto	MD Frede	rick	Ada	amstown				1 ☐ Yes 2X No
	d within 72 hours after death with the Maryland jene. ir than "natural", or Items 23a or 28s-1 show Itla Madical Examinar must be notified at	by Funeral Director	10e. Street and Number 3200 Baker's Cit	rcle		10f. Zip Code	21710	10	g. Citizen of What USA	Country?
	deat	ner	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of H	Hispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No-		merican Indian,
36	or It	y Fu	1 ☐ Never Married 2 📉 Married	1 XYes 2 ☐ No If Yes, Give	1	1 ☐ Yes 2 X No	Specify:	Alcan, etc.)	Specify:	<sup>/hite, etc.</sup> White
Ö	hour: tural'	q pe	3 Widowed 4 Divorced	Year or Dates:	I 100 Dece	danis Haral O				
15	n "na	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of worki d)	ng 16	6b. Kind of Busine	ss/Industry
212	7 2 4 44	E O	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		/GYN			Hosp.	ital
nd	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		,	
yla	Ment Ment Marked	To	Sterile Grumbine					Sappingt		
Maryland 21215-0036	s 1 and 2 should be filled if Health and Mental Hyg item 27 is marked othe other treumatic event,		19a. Informant's Name/Relationship (T)				and Number or Rura			
	1 and Healtl em 2		Francis C. Grumbia 20a. Method of Disposition			JO GOLT Cosition (Name of	Course Rd.		MILLS, Dc. Location - City	
nor	85 = P		1 ☐ Burial 2 🖾 Cremation 3 🖾 F	Removal from State	imber 1a	ndyvalle ium			•	o, PA 17268
Baltimore,	보투 발 글 .		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Signature							al Home, Inc.
ñ	Department		Impo, Q. Sa	I Chack		50 S. Bro	oad St., W	laynesbor	o, PA 17	268
			23a. Party. Enter the disease, or complishock, or heart failure. List only or	ications that caused the dea	th. Do not ent	er the mode of dyir	ng, such as cardiac o	r respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	50	bes	esi	Mellil	us		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	2	0 1	- 1. 0		
п		-	Sequentially list conditions,	Due to (or as a consec	Syr 2	· Man	al P	2010	re .	
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to (or as a consec	quence or):					
, C	le be executed ysicien and e burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
760,	ite be iysicie ne bur	cal	U,	d						
89	ng ph as th	Med	IF FEMALE:			-				
õ	ath ce ttendi or use	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1□Live birth 2□Fet	al death 3	Ectopic pregnancy	,		23d. Date of Month	,
P.O. Box	the de	by Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of a 9☐ Unknown	death 5□	Other (specify) _			Month	Day Year
σ.	that	y Ph	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the u	nderlying cause giv	ren in Part I.	23e. Did toba	cco use contribute	to the cause of death?
Vital Records,	Attending Physicien: The law requires that the death certificate be executed to death. The third certificate has been signed by the ettending physicien and ector. After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	ed b						1 ☐ Yes	2 🖪 № 3 🗆	Probably 4 Unknown
900	law re	Completed						24a. Was an	34b. Were	autopsy findings available
ď	The ete ha	EOC						autopsy performe	death	to completion of cause of ? 'es 2□ No
/ita	cien: ertific ector,	Be (	25. Was case referred to medical examiner?				26. Place of Death		3.10	
<del>_</del>	Physi this c	2	1 ☐ Yes 2. ☐ No	lospital: 1 Inpatient 2			4 Amursing Hon	ne 5 🗆 Residend		pecify)
Division of	ding h. After funer	tlon	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat 2 k? Yes 2 □No	8d. Describe how	injury occurred	
/IS	Atten r deal sctor: by the	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, str			8f. Location (Stre	et and Number or	Rural Route Number.
á	s after	Certification:	4 Homicide	building, etc. (Special	fy)	,,,		City or Town,	State)	rialdi riodio riallibar,
	To the Hospital or Attending Physicien: The law within 24 burus after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my kno	owledge, death	occurred at the tin restigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cau	se(s) and manner	as stated.
	To the vithin 2 To the comple	Mec	29b. Signature and title of certrier	and manner stated.		29c. Licens				onth, Dey, Year)
			) Muly	~e	M.D	> 16	7313		10/2	22/07
	14		30. Name and address of person who co	mpleted cause of death (Iter	m 23a) (Type,	Print)	Wa	3011	more )	21201
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature A	11000 .	~~	JOUNT		
V/e	Registra	ar	OCT 2 9 2007	property of	A STATE OF THE STA	A STATE OF THE PARTY OF THE PAR				

			For State Registrar	State of M	<b>1</b> arylan		artmen <i>rtificat</i>			and M	-	giene Reg. No	200:	7 3462
	Physic		1. Decedent's Name (First, Middle, La Franklin D.		Grove	s					2. Date of De Month Octobe:		, 2007	3. Time of Death 6:45 p N
	/Medi Examii		4a. Facility Name (If not institution, gi Frederick Memoria					Town, or	Location o				County of De	ath lerick
1	Funeral Director		219-34-8446	Sex 7. <i>F</i> 1 M 2 □ F	ige (In yrs.	la <i>st birthday)</i> Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Sept.	th y, Year) 18,	1938 9. B	irthplace (State or Foreig Country) Maryland
	ne Maryland 8a-f show stified at	Director	Usual Residence of Decedent  10a. State  Maryland  Freder	ick	10c. Cit	y, Town or Lo	dlet							10d. Inside City Limits
	th with the	al Dire	10e. Street and Number 6516 Schneider	Drive			10f. Zip	Code 21769	Э			10g. Cit	izen of What ( USA	Country?
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status  1 □ Never Married 2□ 4 Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 ∐Yes 2 ⊠ If Yes, Give Year or Dates	? ] <b>N</b> o		Was Deced If Yes, spec		ispanic Ori in, Mexicar Specify:	gin? (Spe i, Puerto I	cify Yes or No Rican, etc.)	-	14. Race - An Black, Wh Whi Specify:	nerican Indian, lite, etc. te
21215-0036	I within 72 h pene. r than "natu the Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		5+)	life.	dent's Usua kind of wo DO NOT us ICk Dr	rk done d se retired	during mos ()	t of workir	ng		ind of Busines neral T	s/Industry
Maryland 2	buld be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Las Alexander Groves	•							(First, Middle, eeman	Maiden	Surname)	
	and 2 sho salth and 127 is m er traum	8	19a. Informant's Name/Relationship Ethel Groves/ Wif								Route Number Middle			
Baltimore,	Pages 1 ament of He ant; If Item ury or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			Place of Dispo emetery, crei arklaw	matory or o	ther plac		Octork 2	i		cation - City o	or Town, State  Maryland
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lice	nsee		Fr 50	2.Name and	d Addres J. vers	s of Facilit Coll Sity	ins F 31vd,	uneral W, Si	Hom lver	e Inc. Sprin	g, MD 20901
100	Physician /Medical	A T	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Aspirat	ion P	neumon		e of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner			Due to (or a Termina b.	s a consequ 1 Dem	uence of): entia		-						
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or a	a Lambia da									
Box 6	ath certifi ttending I or use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 🗆 Feta	Ideath 3	Ectopic pr Other <i>(sp</i>						23d. Date of d Month	elivery Day Year
rds, P	quires that the de in signed by the a uld be detached f	þ	Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	nderlying c	ause give	en in Part I.					to the cause of death? Probably 4ื¥Unknowi
Division or Vital Records, P.O.		Completed						-		_	24a. Was autop perfo 1□ Yes		death?	
r Viit	nysician: nis certifica director, p	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	ient 2□	ER/Outpatier	ıt 3∐ DO	A Othe			Check onl o		6 ∏Other (Sr	pecify)
ision o	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification:	27. Manner of Death  1 Anatural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be determined	e ne Bloom of in	ay Year)	28b. Time of Injury ome, farm, str	М			No 2	8d. Describe h	now injur	y occurred	Rural Route Number,
2	spital or / ours after neral Dire filled in b		4Tronnicide	building, e	etc. (Specify	/)			ne date an		City or Tou	vn, State	)	
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only 2 Medical Exa	miner: On the basis and manner s	of examina	tion and/or in	vestigation	, in my o	pinion, dea	th occurre	ed at the time,	date and	d place, and d	ue to the cause(s)
	To the To the Comple	Σ	29b. Signature and title of certifier	- M				License					-	nth, Day, Year) 12, 2007
	>		30. Name and address of person who Sibte Kazmi, MD	completed cause of 814 To1	death (Item Lhous	23a) (Type, Aven	Print) ue, F	rede	rick,	MD	21701			
13	Sta Registr	_	31. Date filed (Month, Day, Year)		trar's Signa	ture	als o							

Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending

Baltimore, Maryland 21215-0036

Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlying	g cause given in Part I.		ise contribute to the cause of death?  No 3 □ Probably 4 □ Unknown
				24a. Was an autopsy performed? 1  Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 ☑ Inpatient 2 □	ER/Outpatient 3	Othor	Home 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death 1   Natural 5  Pending 2  Accident investigation	the same are a second as a second as	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Special	ome, farm, street, fact fy)	ory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number, )
29a. Certifier 1 M Certifying Phy (Check only one) 2 ☐ Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurration and/or investigati	ed at the time, date and place ion, in my opinion, death occ	ce, and due to the cause(s) curred at the time, date and	) and manner as stated. d place, and due to the cause(s)
29b. Signature and title of certifier		2	29c. License number	29d. Dat	te signed (Month, Day, Year)
> Belohi	_ m	D	128035		tober 12,2007

Piscataway Rd. #310

State Registrar

Medical

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BASIRMOHMAD F. KOLIA.M.D.

32. Raistrar's Signature

		ı	For State Registrar	State of Maryla	and / Dep	artme			-	e o o o ¬	34624
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Las 50 N A     Sovia A     Facility Name (If not institution, give	60,	TTLI	E		OCI	te of Death onth		3. Time of Death 6:30PM
	Funeral Director		### HEBREW HOME OF GR  5. Social Security Number 6. Security 1		rs. last birthday,	If Und Month	ROCKVILI er 1 Year   If Under 2 s   Days   Hours	24 Hrs. 8. Da Min. (M	ite of Birth fonth, Day, Yea 23/1930		RY blace (State or Foreign ntry) MORE, MD
	th the Maryland or 28e-f ehow e coulded at	Director	10a. State 10b. County  MARYLAND MONTGOM  10e. Street and Number		City, Town or L	LE	lip Code		10g. C	Citizen of What Cou	10d. Inside City Limits 1 X Yes 2 □ No ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. I with proportent: If Item 27 is marked other than "natural", or Items 23a or 28e-f show eny injury or other treumatic event, the Medical Esacid at must be notified at once.	by Funerai	6105 MONTROSE ROA  11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	D  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	U.S. 13.		20852 redent of Hispanic Orig pecify Cuban, Mexican, 2  No Specify:		es or No- etc.)	USA  14. Race - Ameri Black, White, Specify: WH]	etc.
Baltimore, Maryland 21215-0036	ed within 72 ho ygjene. her than "natur it, tre Medicalist.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5+)	(Give	a kind of v				Kind of Business/In	i.
laryland	2 should be fill and Mental H is marked oth eumatic even	To Be	17. Father's Name (First, Middle, Last) SIMON WAITSMAN  19a. Informant's Name/Relationship (7)			_	ss (Street and Number	TILL r or Rural Rout		EE or Town, State, Zij	
imore, N	Pages 1 and 1 nent of Health ant: If Item 27 ury or other tr		ELLIOT S. GOTTLIE  20a. Method of Disposition  1 Donation 5 Other (Specify	206	). Place of Disp	osition (A	LLOWSTONE D	Date	20c.	ETHESDA,  Location - City or To	own, State
Balt	permit. Departr Importa		21. Signature of Funeral Service Licen	see	E]	2. Name DWARI D91 I	and Address of Facility SAGEL FUN ROCKVILLE F	NERAL D	IRECTIO OCKVILL	N, INC. E, MD 20	0852 Approximate Interval Between
	cate be executed which is the burial-transit the bu	dical Examiner	shock, or heart failure. List only is Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. SENILE	sequence of): CURII sequence of):		NTIVA YTRIACT	INF	ECT16.	n	Onset and Death
.O. Box	The law requires that the death certificate ite has been signed by the attending phy page 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of predictions of the second of the	etal death 3	⊒Ectopic ⊒ Other (	pregnancy specify)			23d. Date of deliv Month	ery Day Year
S, D	w requires that the de been signed by the a should be detached		Part II. Other significant conditions of	entributing to death but not	resulting in the t	underlying	cause given in Part I.	_			he cause of death? bably 4 Unknown opsy findings available
/ital Re	cian: The lav ertificate has ector, page 2	Be Completed	25. Was case referred to medical examiner?				. /	_	autopsy performed?	prior to co	empletion of cause of
Division of Vital Record	To the Hospital or Attending Physicien: The law within 24 buous after death.  To the Funerel Director Atter this certificate has completely filled in by the funeral director, page 2	Certification; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined		28b. Time of Injury	of M	28c. Injury at Work?	28d. D	escribe how in	and Number or Run	
٥	ne Hospital or n 24 hours afte ne Funerel Dir	Medical Ce	29a. Certifier (Check only one)	ysician: To the best of my siner: On the basis of exam and manner stated.	knowledge, dea ination and/or ii	th occurrenvestigation	ed at the time, date and on, in my opinion, deat	d place, and du h occurred at t	ue to the cause the time, date a	(s) and manner as s ind place, and due t	stated. o the cause(s)
)	within 2 To the	W	29b. Signature and title of continer  Bandane	Lelu	uy		9c. License number D 354	36	29d. C	Date signed (Month,	Day, Year) 2, 2007 1852.
	Sta Registr		30. Name and address of person who BARBARA A CONTROL A C	32 Alegistrar's Signary	HOW	120	SERP, RE	DEKVI	llo,	4020	0852.

07-08104 Do

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

naid Gaskins		1- For State Registrar Certific	ent of Health and Mental Hyg cate of Death	Reg. No. 2007 31, 52
Physicia dical Exami		1. Decedent's Name (First, Middle, Last) DONALD GASKINS		Date of Death Month Day Pear October 17, 2007  3. Time of Death 1735 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		Suburban Hospital	Bethesda	Montgomery
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 1 M 2 F 39	Months Days Hours Min	B. Date of Birth (MW/DD/YYYY)  9. Birthplace (State or Foreign Washingtor Country)  Country)  DC
v any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town		10d. Inside City Limits
Maryland 28a-f show datonce.	ē	Maryland Prince George's  10e. Street and Number	Mitchellville	1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	725 St. Michael's Drive	10f. Zip Code 20721	10g. Citizen of What Country?  USA
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland thi and Menial Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f shi umadic event, the Medical Examiner must be notified at once		11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( Speci	fy Yes or No- 14. Race - American Indian, Black,
r death or ite	Funeral	1 X Never Married 2 Married Armed Forces?  1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto Ric	77 - 1-
urs afte tural".	à	Widowed 4 Divorced If Yes, Give Year or Dates:     Decedent's Education (Specify only highest grade completed) 16a	1 Yes 2 X No specify:  Decedent's Usual Occupation (Give kind of world)	Specify: Black k done 16b. Kind of Business/Industry
6 72 hours un "naturi cal Exami	leted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retired	)
21215-0036 uld be filed within 7 Mental Hygiene: marked other than c event, the Medica	Comple	12 17. Father's Name (First, Middle, Last)	Security	Private
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. Itant: If item 27 is marked other than on other traumatic event, the Medical	Be	Jose L. Gaskins	Patricia	irst, Middle, Maiden Surname)  A. King
2121 hould be fill nd Mental F is marked itic event, I		19a. Informant's Name/Relationship (Type, Print )	9b. Mailing Address (Street and Number or Rura	al Route Number, City or Town, State, Zip Code) 20721
ore, MD 2 ges I and 2 shoul of Health and N If item 27 is m ther traumatic	1	Patricia K. Gaskins Mother 7		rive Mitchellville, MD  Date   20c. Location - City or Town, State
Baltimore, MI permit. Pages   and 2 s Department of Health a Important: If item 27 injury or other traum:		1 X Burial 2 Cremation 3 Removal from State crema	atory or other place)  rection Cemetery 10/24	
Baltin permit. Pa Departmen Importan injury or	1	4 Donation 5 Other Specify: Result 21. Signature of Forteral Service Licensee	<del>-</del>	an Funeral Service, Inc.
<b>8</b> 4 4 4 4 5 6 5 6 6 6 6 6 6 6 6 6 6 6 6 6		232/4	4001 Benning Road, N	WE Washington, DC 20019
Physician /Medical		23a. Part I. Enter the disease, or domplications that caused the death. Do failure. List only one cause on each line.		Approximate Interval Between Onset and Death
`xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Dilated cardion allowed Due to (or as a consequence of):	/	Death
	إ	Sequentially list conditions, b.		
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Discass or lingury that initiated		
ted J ansit	Exal	events resulting in death) Last  Due to (or as a consequence of):  d.		
68760, certificate be executed nding physician and ise as the burial - transit	Medical	X UNPENDED AMENDED 7, perME, g872	10/30/07 TT	
760, icate be ex physician the burial	/Mec	IF FEMALE: 23c. If yes, outcome of pregnance	У	23d. Date of delivery
	hysician/	past 12 months?  4 Pregnant at time of death	<ul><li>Fetal death 3 Ectopic pregnance</li><li>Other (Specify)</li></ul>	y Month Day Year
<b>m</b>	hysi	1 Yes 2 No 9 Unknown 9 Unknown		
ires that the signed by lbe detach	by P	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 ✔ Unknown
rds, requires been sig	Completed			24a. Was an 24b. Were autopsy findings available
ecor ne law te has l ge 2 sh	gm			autopsy performed? performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
	Be C	25. Was case referred to medical	26.Place of Death (Check onl	
<u> </u> ₽ 2 2 2 2 2 2 3 2 3 2 3 2 3 2 3 3 3 3 3	10 E	examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/		
F E . \ C	.i.	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)	. Time of Injury 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work?	8d. Describe how injury occurred
Division tal or Attendirs after death.	ficat	2 Accident Investigation 28e, Place of Injury - At home.		8f. Location (Street and Number or Rural Route Number, City
Div pital o ours af eral D	Certification	4 Homicide determined (Specify)		or Town, State)
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, done)  2 Medical Examiner: On the basis of examination and/or		
To 1 To 1	Medi	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		Pot A Popls	O.C.M.E.	October 18, 2007
	ŀ	30. Name and address of person who completed cause of death (Item 23a	)	
-		Patricia Aronica-Pollak MD. Assistant Medical Exa		MD 21201
24	ate	31. Date filed (Month, Day Year) 32. Registrar's Significant files (Month, Day Year)		

DHMH 17 Rev 1/2001 OCME 2006

			For State	State o	of Marylan		artment of t			/lental		ene . No. <b>?</b>	0.7	01.60	_
			Registrar  1. Decedent's Name (First, Midd	le, Last)			rimouto or	Doan	,	2. Date o	f Death	20	U/	3. Time of Death	9
И	Physicia /Medic		DA	VID RANDA	LL HOLM	ES				Month O	CT 9	<sup>Day</sup> 2007	Year	11:37 PM	1
	Examin		4a. Facility Name (If not institution	-			4b. City, Town,					4c. County			
			NATIONAL NAV					THESD	A er 24 Hrs.	8. Date o	f Diab	MON	TGOM		_
tp:	Funeral Director		5. Social Security Number 577–46–1606	6. Sex 1 <b>X</b> M 2 ☐ F	7. Age (In yrs. <b>7</b> 3		Months Days			(Month	. Day. Y	1934	Cou	place (State or Foreig intry) YORK	n —
	land bw		Usual Residence of Decedent  10a. State 10b. County	,	10c. City	y, Town or Lo	ocation							10d. Inside City Limits	S
	Mary I-f she fied a	tor	VIRGINIA ALE	XANDRIA	ALI	XANDR	IA							1 <b>X</b> Yes 2□No	Э
	th the or 288 e noti	Director	10e. Street and Number				10f. Zip Code				10g	. Citizen of \	What Cou	intry?	
	23a ust b		309 YOAKUM PA				22304					JSA			
	er dea Items	Funeral	11. Marital Status	Armed F		S.   13.	Was Decedent of If Yes, specify Cul	Hispanic C ban, Mexic	origin? (Sp an, Puerto	ecify Yes on Rican, etc	r No- .)		ce - Amen ck, White	ican Indian, , etc.	
36	urs aft	by F	1 ☐ Never Married 2 ▼ Mar 3 ☐ Widowed 4 ☐ Divorce	If Yes, Gi	2□No ive Date <b>1956-8</b>	33	1□Yes 2XNo	Specif	y:			Specify	. CAU	CASIAN	
Ö	72 hou natura lical E	ted		nt's Education est grade completed)		16a. Dece	edent's Usual Occu	pation	ast of work	kina	16	b. Kind of B			
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or hems 23a or 28a-f show he Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (	(1-4or 5+)	life.	DO NOT use retir	ed)	000 07 11071	/9			COM	DAD CUANT	
	be filed within 72 hours after death with the Marylar ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		17. Father's Name (First, Middle	5+		U.	S. ARMY	18 Mot	her's Nam	e /First Mi	ddle Ma	U.S.		RNMENT	_
Maryland	ould be f Mental H larked of latic ever	Be C	ROBERT SINCL	· · · · · · · · · · · · · · · · · · ·	c							RANDAL	_		
ary	should band Ment s marked umatic e	2	19a. Informant's Name/Relation		<u>.                                    </u>	19b. Mail	ing Address (Stree							ip Code)	_
	nd 2 alth a 27 is r tra		MARIAN HOLM	ES - WIFE		309	YOAKUM PI	CWY #	1801,	ALEX	ANDI	RIA, VA	223	04	
ore	ges 1 a t of Hea lfitem or othe		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 □Removal from	/	Place of Disp cemetery, cre	osition (Name of ematory or other pl	ace)	UKN	Date	20	c. Location	- City or 1	Town, State	
Ē	Pages ment of tant: If its jury or o		4 □ Donation 5 □ Other (	Specify)			CREMATO	1						H,VA 22042	<u>'</u>
Baltimore,	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service	Holder Holder		2	2. Name and Add							E 22203 INGTON, VA	
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that it only one cause on	caused the deat each line.	h. Do not er	nter the mode of dy	ing, such	as cardiac	or respirat	ory arres	t,		Approximate Interval Between	
1	Physician		Immediate Cause (Final disease or condition	a M	ETASTAT:	IC PRO	STATE CA	NCER						Onset and Death	
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):									
		e.	Sequentially list conditions,	b	o (or as a conseq	uence of):									_
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>\</b>											
oʻ	be executed ician and burial-transit	Exa	resulting in death) Last	CDue to	(or as a conseq	uence of):									
8760,	cate be executed oblysician and the burial-transit	dical		d											
9	ertific ding p	Mec	IF FEMALE:	220 If you or	utcome of progn	anov									_
Вох	requires that the death certific een signed by the attending p hould be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome pf pregna birth 2 □ Feta anant at time of c	al death 3	☐Ectopic pregnar☐Other (specify)	су					ate of deli onth	very Day Year	
P.0.	ires that the de signed by the I be detached I	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unki											
	s that ined b e deta	by Pi	Part II. Other significant condi	ions contributing to	death but not res	ulting in the	underlying cause g	iven in Pa	rt I.	23e.	Did toba	icco use con	ntribute to	the cause of death?	
ğ	w require been sig should b		ļ								1 Tes	2 <b>∏</b> No	3 □ Pr	obably 4 Unknow	vn
ecc	aw Is b	Completed								24a.	Was an autopsy	24b.	Were au	topsy findings availab completion of cause of	le f
or Vital Records,		Con	No. 2 April 10 Company and 10 Property April 10 Property and 1							1 <b>-</b> X	perform res 2	ed? No	death? 1 ☐ Yes	2₩ No	
Vit	Physician: The tries certificate ral director, pag	Be	25. Was case referred to medic examiner?	Hospital:				thor.		th (Check					
ō	Phys r this ral dir	는 -	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date	e of Injury	ER/Outpation 28b. Time	SILL SUIDON	4 🗆	Nursing H			ce 6 Ot v injury occu	- ' '	cify)	_
Division	Attending r death. ector: After by the fune	Certification:	1 X Natural 5 □ Pend 2 □ Accident inves	ing ( <i>Mo</i> tigation	nth, Day Year)	Injury		ork? ⊒Yes 2	□No						
Visi	Attend or death. rector: / by the f	ifica	3 ☐ Suicide 6 ☐ Could	minad Zoe. Plac	ce of injury - At h ding, etc. (Speci	ome, farm, s fv)	treet, factory, offic	е			tion (Stre		ber or Ru	ıral Route Number,	_
	pital or Attending ours after death.  eral Director: After filled in by the funer	Cert								0.1.9					
	Hos Hos Fun	edical		ing Physician: To the il Examiner: On the and ma											
	To the within 2 To the complex	M	29b. Signature and title of certif		. 1	11 /	_	nse numbe		<b>TT</b> \		_		h, Day, Year)	
) .	20		Nove	d H.K	orsto.	MIL	/ 036	-1056	99 (	Tr)	1	10-1	2-1	2007	
			30. Name and address of person				e, Print)					(EDICA)		NTER	
	C+	ate	DAVID A. KI 31. Date filed (Month, Day, Yea		MC U Registrar's Sign	SA ature		BE'	THESD	A MD	2088	9-560	0		
	Regist			2007	Muse A		new le								
DI		2001				-									_

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 5:35 аМ Immacolata Holland October 0 12 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 10101 Governor Warfield Parkway, #212 Howard Columbia 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday, If Under 1 Year | If Under 24 Hrs. **Funeral** Days Months Hours Min 1 □ M 2 🖾 F Italy Director 213-56-8616 May 31, 1930 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County sa or 28a-f show t be notified at 1 ☐ Yes 2 No Director Maryland Howard Columbia 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a 10101 Governor Warfield Parkway, #212 21044 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Q Q 3 Widowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Giuseppe Vitti Carmella Mega 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 Benjamin F. Holland, Jr. - Husband 10101 Governor Warfield Parkway, Apt #212, Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any Injury or once. = 5 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery : 10/16/2007 Silver Spring, Maryland 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, 21. Signi 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure Immediate Cause (Final **Physician** Cardiac Pulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Ovarian Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by should b 1 Tyes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' certificate 1 ☐ Yes 2 ☐ No 1□ Yes 2 No Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 🛭 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation (Month, Day Year) 1 X Natural Injury 24 hours after death. Funeral Director: A 2 Accident 1 ☐ Yes 2 ☐ No 3☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 ☐ Homicide filled in Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 300 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rony Tanios Abdallah, M.D., 104 Ridgely Avenue, Suite 201, Annapolis, Maryland 21401 31. Date filed (Month, Day, Year)

OCT 15 32 Registrar's Signature State 5 2007 Registrar

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2007

1 5 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PA: 1 A DEVORE NO 4203 QUEENSBUSIN IEU MY GHTSU: "No MIS Zo ZF)

29d. Date signed (Month, Day, Year) October 4, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend in terms Maryland / Perpartition 874 Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Oct 10,2007 **Physician** Casper E. Heindl 9:01pm M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery

9. Birthplace (State or Foreign Country)
Wash DC Bethesda er 1 Year | If Under 24 Hrs. Suburban Hospital 8. Date of Birth (Month, Day, Year)
Dec 28, 1929 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1 ▼ M 2 □ F 578-34-2286 77 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1√1 Yes 2 No Director MD Montgomery Potomac 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States

14. Race - American Indian,
Black, White, etc. 20854 8512 Victory Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give ★ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify: White 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Printing/Owner Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Machen Raymond A. Heindl 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8512 Victory Lane, Potomac, MD 20854 Nancy Heindl/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 10-13-07 Rock Creek Cemetery Washington DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signature of Euneral Service Licensee 20016 5130 Wisconsin Ave, N.W. Washington DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Lung Cancer /Medical Due to (or as a consequence of): **Examiner** Malignant Pleural Effusions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ģ Y Yes 2 No 3 Probably 4 Unknown Coronary Artery Disease Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2√ No 1□ Yes To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certificat completely filled in by the funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 3□ DOA 2 ☐ ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 29c. License number 46 am MD D 5 99 80 Spelistatis 10/11/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bandra M. Delistathis 8600 Old georgetown Rd, Bethesda, MD 20814

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)
OCT 15

OCT

2007

2101

Heinall, Caspert

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of beath 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Helena Chalaron Hardy 12 2007 11:05 P M October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Montgomery Gaithersburg If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 LA 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 X Yrs 99 1908 Director 215-52-7577 Aug. 4, Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f ehov 1 Yes 2 No Director MD Montgomery Derwood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7704 Dew Wood Drive 20855 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. r then "natural", or Items: 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) les 1 and 2 should be fill of Health and Mental Hill frem 27 is marked off ir other treumatic event Be James Chalaron Estelle Delery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7704 Dew Wood Drive, Derwood, MD 20855 Stephen Chalaron Hardy / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 Termation 3 Removal from State October 13 permit. Page Department of Important: If eny injury or once. 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Par 1. Erief the disease, shock of lear failure. Li Immediate Gusse (Final disease or condition resulting in death) Approximate Interval Between Onset and Death or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line faclure to Thrive Physician One month /Medical Examiner Alzheimers Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its tool are not as a second cause). Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rector, page 2 s autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cai (Check only one) and manner stated the within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 004115 October 13,2007 V. Reduct als 201 RUSSELL AVENUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAITHERS BURG NID 2087 BIRSCITBACK MN. IV. KOBERT 31. Date filed (Month, Day, Year) 32 egistrar's Signature State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Physical Physic 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician INd October 2.00 DYIa 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Center andollstown HIMOVR ltosinta If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 🖺 F 223-04-5922 71 Director 01/07/1936 Jamaica Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1XYes 2 No Director Prince Georges MD Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20782 6020 Sargent Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: ρ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. I other than "I vent, the Mec Elementary/Secondary (0-12) College (1-4or 5+) 12 Certified Nursing Assistant Healthcare permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, : 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hilda Maude McDermott Aubrey George McIntosh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3624 Langrehr Road Windsor Mill, MD 21244 Ms. Shelion Hinds/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Cemetery 10/18/2007 4 Donation 5 Other (Specify) Brentwood, MD Ft. 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 21. Signature of Funeral Service Licensee 23a. Part1. Exter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3401 Bladensburg Road Brentwood, MD 20722 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of): Box 68760, physician Physician/Medical attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. | 9□Unknown 9 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 2 No 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending Injury 1 □ Yes 2 □ No investigation within 24 hours after death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, 29b. Signature and title of certifie ဂ္ Or dame and address of person who completed cause of death (Item 23a) (Type, Print) Me MO ICI ton 401

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

DHMH 17 Rev 1/200

Registrar

			For	State of Man				lental Hyg	iene	34633
			State     Registrar  1. Decedent's Name (First, Middle, La)	st)	Ce	rtificate of	Death	2. Date of Deat	ng. No U U /	3. Time of Death
	Physici /Medic	cal		ARCELE	HAM		Dr Location of Death	Month (O	O3 O7	(338° M
	Examir Funeral Director	ier	Anne Arune 5. Social Security Number 6. S 216.38-7930	el Medico	Center yrs. last birthday) 65 Yrs.	1	na Polis	8. Date of Birth (Month, Day, Dec. 2	Anne A	1 1
Q	e Maryland	ctor	Usual Residence of Decedent  10a. State  10b. County  Oueer	Λ	c. City, Town or Lo	Sonvil	le			10d. Inside City Limits
30	72 hours after death with the Maryland natural', or items 23s or 28s-1 show disal Examiner must be nutilised at	Funeral Director	10e. Street and Number  3 23- Perry's  11. Marital Status  1 □ Never Married 2 □ Married	Corner  12. Was Decedent Eve Armed Forces?  1   Yes 2   10   Yes 2   10   10   10   10   10   10   10	Road rin U.S. 13.		38 Hispanic Origin? (Span, Mexican, Puerto		0g. Citizen of What Co U. S. A 14. Race - Ame Black, Whit	Prican Indian,
21215-0036	n 72 hours al "natural", or edical Exam	by	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's E (Specify only highest gra	If Yes, Give Year or Dates:	16a. Dece	1 ☐ Yes 2 ☑ No  dent's Usual Occup kind of work done		kina	Specify: 3 /	a CK Industry
	filed within Hygiene. thar than " int, the Mas	Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last	College (1-4or 5+)	life.	DO NOT use retire	river	ne (First, Middle, I	OMMUNHY Maiden Sumame)	Action Agency
Maryland	2 should be and Mental is marked o	To Be	<u>- 1 </u>	arcelle H			Mari	/ V,	COOPEY. City or Town, State,	
-	of Health of Health if itam 27 or other tra		Mary Virg.  20a. Method of Disposition  1 Translated 2 Cremation 3 E	Hemoval from State			corne	r Gras	20c. Location - Cy or	
Baltimore,	permit. Pages Depertment of important: if it any injury or o		4 Donation 5 Other (Special  21. Signature of Funeral Service Lices	y)	Robinsa	n's Ceme 2. Name and Addre 1 enry Fu	tery 101	tone, P. A	Grasonvi bridge, M	Iley MD.
	Physician /Medical Examiner		23a. Pant Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line.  a. Due to (or as a co	ngis Car	ter the mode of dyn	ng, such as cardiac	or respiratory arr	priage, Mi	Approximate Interval Between Onset and Death
,160,	te be executed ysicien end se burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co						
O. Box 68	The law requires thet the death certificat tie hes been signed by the ettending phy page 2 should be detached for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	y		23d. Dale of de Month	livery Day Year
rds, P.	w requires that been signed t should be deta	þ	Part II. Other significant conditions of	contributing to death but n	ot resulting in the u	inderlying cause gr	ven in Part I.	23e. Did tol	pacco use contribute to	o the cause of death? robably 4 Unknown
Vital Records,		Completed						24a. Was a autops perfori		utopsy findings available completion of cause of 2 No
Vita	Physician: Th this certificate ral director, pag	9 Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \)	Hospital: 1 Inpatient	2 - 50/0	20 DOA OH	hor	th (Check only on		
ion of	ath. rr: After ne fune	ation: To	27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injury (Month, Day Yo	2 ☐ ER/Outpatie 28b. Time o Injury	f 28c. Inju	4 Livuising n		ence 6 ⊡Other <i>(Spe</i> ow injury occurred	city)
Division	To the Hospital or Attand within 24 hours after death To the Funeral Director: . completely filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (	Specify)			City or Tow		
	a Hosp 24 hou a Fune etely fil	Medical	29a. Certifier (Check only one)  Certifying Pl 2 Medical Example (Check only one)	nysician: To the best of n niner: On the basis of ex and manner stated	amination and/or ir	h occurred at the ti vestigation, in my i	ime, date and place opinion, death occu	, and due to the e rred at the time, d	ate and place, and du	e to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certain	J. Delo.	tous	29c. Licen		1	9d. Date signed (Mon	
•			30. Name and address of person why	completed cause of death	(Item 23a) (Type	crint)	- H	11.12 1	NA APALA	M D21401
	Sta Registi		731. Date filed (Month, Day, Year)	32 bgistrar's	Signature	DEFENS	SE [ 19	m wm/	NNIT COS	111/11/11/11/11

				ertificate of Death	Reg. N	2007 34634
	<sup>n</sup> Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 10/13/20	3. Time of Death 8:26 a <sup>M</sup>
	/Medic	al	Robert Howell  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
	Examin	er	Spa Creek Center	Annapolis		Anne Arundle
	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea.	9. Birthplace (State or Foreign Country)
	Director		217-36-1798 1™ 2□ F 71 Yrs.		July 11,19	936 Washington DC
	land bw t	}	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Mary a-f sh	tor	Maryland Anne Arundle Edgewate	er		1 □ Yes 2 No
	or 28s	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	ath wis 23a nust b		437 Poplar Leaf Drive	21037		ited States 14. Race - American Indian,
	items items	Funeral	1 □ Never Married 2 □ Married 1 □ XI Yes 2 □ No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
0030	ursaf al';or Exam	by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates: 1955–59	1 ☐ Yes 2 ☐ No Specify:		Specify: White
2	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Menth Hyglene. If marked other than "natural", or items 23a or 28a-f show ltem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired)	ding 16b.	Kind of Business/Industry
V	within sne.  than '	ldu	Elementary/Secondary (0-12) College (1-4or 5+)	Sales Consultant		Printing
<b>D</b>	Hygie Hygie other ent, th	Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide	
yıand	should be nd Mental marked c	To B	Roy Howell		h Pulliam	
Mary	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the Me		, , , , , , , , , , , , , , , , , , , ,	ailing Address (Street and Number or Rui		
45	of Health of Health ltem 27 i		20h Place of Di			, Maryland 2103/ Location - City or Town, State
5	ages nt of H t: # Ite		1 □ Burial 2 ☑ Cremation 3 □ Removal from State	crematory or other place) r Crematory Inc.10/	16/07 Fr	ederick, Maryland
Baltimor	permit. Pages 1 Department of H Important: If Ite any Injury or ot		21 Cignoture of Financial Sendre Licenses	22. Name and Address of Facility		erecesoa de la compania de la compa
ñ	Dep Imp any					ck, Maryland 21702
ľ	3		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only on cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		regulting in death)	cikebol shadis		- 14
	/Medical Examiner		Due to (or as a consequence of).			
6		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Under Virg. Cause (Disease or injury			
	ecuted ind transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)			
58760,	icate be executed physician and s the burial-transit	a E	Due to (or as a consequence or)			
289	ficate physics the	edical	d			
Box	death certifi e attending d for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery  Month Day Year
	0 0 0	sicis	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  1 □ Yes 2 □ No 9 □ Unknown	5 Other (specify)		monar bay
<u>Р</u> .	The law requires that the de ate has been signed by the a page 2 should be detached		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
ds,	w requires that s been signed to should be deta	d by			1 ☐ Yes	2 No 3 Probably 4 Unknown
Records,	aw red s beer s shou	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	hysician: The lav his certificate has I director, page 2	mo			performed 1 Yes 2 ≥	i? death? 1 ☐ Yes 2 ☐ No
Vita	iclan: sertific ector,	Be (	25. Was case referred to medical examiner?	Othor	ath (Check only one)	
	Physic rthis or ral dir	1-	27. Manner of Death 28a. Date of Injury 28b. Tir	ne of 28c. Injury at	fome 5 ☐ Residence 28d. Describe how i	e 6 ☐Other (Specify)  njury occurred
0	nding Ph th. : After th e funeral	tion	1 S → Ratural 5 □ Pending (Month, Day Year) Inju 2 □ Accident investigation	M 1 Yes 2 No		
Division or	r Atter er dea rector by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, itate)
ō	ital or irs aftural Di iral Di		29a, Certifier 1 Certifying Physician: To the best of my knowledge,	doath occurred at the time, date and place	and due to the caus	se(s) and manner as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Medical	29a. Certifier (Check only one) 1 Medical ExamIner: On the best of my knowledge, (Check only one) and manner stated.	for investigation, in my opinion, death occ	urred at the time, date	and place, and due to the cause(s)
	To the within To the compl	Me		29c. License number 3		Date signed (Month, Day, Year)
)			> > (Jennes) >	6 29026		10/15/3007
	-		30. Name and address of person who completed cause of death (Item 23a) (T	Special Drive	Cho. Lu	, MO 2/4/5
Ì		ate	31. Date filed (Month, Day, Year)  OCT 1 6 2007  Security 132. Registrar's Signature	books		
	Regist	trar	OUT TO TOOL	7		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 13,2007 Physician 6:00 A M WENDLE HALLER .TAMES /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Brunswick 511 9th Ave. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☑ M 2 □ F Maryland 219-20-2467 79 Aug. 21, 1928 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at 10d. Inside City Limits 10c. City, Town or Location 10a State 1X Yes 2 □ No Director Brunswick Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21716 United States 511 9th AVE. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 No Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1947-55 Specify Specify. ş 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Electrical Foreman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Selby ဥ Irving Haller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9th Avenue, Brunswick, Maryland 21716 Beverly Haller/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Park Heights Cemetery 10/17/2007 Brunswick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Stauffer Funeral Home P. A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) - D Physician lung 9 /Medical Due to (or us onsequence of): Examiner zcuren Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 🗌 Yes 2 No 3 Probably 4 Unknown 00576 Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CUD 24a. Was an autopsy performed? Yes 2 1∏ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 1 6 2007

210506

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM/29d PHYS C872 10/29/07 WS State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** EDRAE 100 /Medical 4b. City. Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) Examiner Date of Birth (Month, Day, Y 7. Age (In yrs. last birthday **Funeral** Days 1 M 2 □ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show notified at 1 ☐ Yes 2 ☑ No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or items you loury or other traumatic event, the Medical Examiner must be none. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 ShITE Specify: Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EQUIPMENT OFFRATOR CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ DIDEON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PRIE MD . 2 W61
206. Location - City or Town, State THRISTINE ANN JAEGER, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation Date 3 Removal from State EDENT CREMATORY 10-23-07 HANONER MO. 5 ☐ Other (Specify) 4 ☐ Donation 21. Signatur of F 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, line. e or complications that List only one cause or Approximate Interval Between Onset and Death Part1. Enter the disease shock, or heart failule. L immediate Cause (Final disease or condition resulting in death) Physician MUSCULA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by DIAIZIZHS 21 NO 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy CHISONIC 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this s after death.

I Director: After this of in by the funeral d 27. Manner of Deat

1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft

To the Funeral DI

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLEN BURNIE CRAIN H & 12 CICHARD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State g Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** RUBY JONES October 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Plata If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🔀 F 118-20-1622 93 FLORIDA Director 29, 1913 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2X No Director MARYLAND PRINCE GEORGES FORT WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1606 ARAGONA BLVD 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify. Baltimore, Maryland 21215-0036 δ 3 X Widowed 4 ☐ Divorced BLACK Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8th College (1-4or 5+) RETIRED HOUSEWIFE PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BURN ROBINSON HENRIETTA RILEY ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MERVYN JONES JR. / SON 1606 ARAGONA BLVD. FT. WASHINGTON, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 □Removal from State 10/20/07 4 ☐ Donation 5 ☐ Other (Specify) RESURRENTION CEMETERY CLINTON, MARYLAND 21. Signature of Funeral Service Licensee THORNTON FUNERAL HOME, P.A. LEON THORNTON MO0582 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of) Due to ( **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pt 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1☐ Yes 2 4 No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Ampatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Netural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Holly Lane Suite 107 Waldorf, MD 20001

10/15/2007

		•	_ FUI	partment of Health and N <i>ertificate of Death</i>	lental Hygi Ber	ene g. No2007 34638
	Physici	an	Decedent's Name (First, Middle, Last)		Date of Death     Month.	3. Time of Death
	/Medic	al	James Blake Johnston  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	October	09 2007 10:20 P M
Ì.	Examin	er	Anne Arundel Medical Center	Annapolis		Anne Arundel
T.	Funeral Director		5. Social Security Number  6. Sex 1 M 2 F  7. Age (in yrs. last birthda	Months Days Hours Min.	8. Date of Birth (Month, Day, 02/25/19	Year) 9. Birthplace (State or Foreign Country) Pennsylvania
	ס		Usual Residence of Decedent	Location	02/23/1.	10d. Inside City Limits
	Maryla f shov led at	io		Locaton		1 □Yes 2X No
	h the or 28a-	irec	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	ath wil	ral	5905 Alexander Lane	20751		United States
36	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☒ No  If Yes, Give  Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> <li>Yes 2 No Specify:</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
9	'2 hour natural ical Ex	ted t	15. Decedent's Education 16a. De	cedent's Usual Occupation	ing 1	6b. Kind of Business/Industry
Maryland 21215-0036	vithin 7 ane. than "n ie Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Teac	ive kind of work done during most of work e. DO NOT use retired) her	mg	Education
2	~ O W	Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, M	
ylan	ould be Mental arked o atic eve	To B	John Hamilton Johnston	Mary Eli		<del></del>
Mar	d 2 sho th and 7 is mi traum			ailing Address <i>(Street and Number or Rur</i> D Alexander Lane, D		
ē,	s 1 and Healt item 2 other		20a. Method of Disposition 20b. Place of Dis			Oc. Location - City or Town, State
E O	Page ment o ant: If ury or		1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Cr	rematory 10/1	1/2007 I	Edgewater, Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev once.		21. Signature of Europa Service Incense	22. Name and Address of FacilityGeo 2973 Solomons Isla		
		,	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arre	st, Approximate Interval Between Onset and Death
	Physician / /Medicai		Immediate Cause (Final disease or condition resulting in death)  a. Due to ( as a consequence of):	<u> </u>		hours
P	Examiner		Sequentially list conditions b. 15 cheric	colitis		days
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	so a tha		2000/1/20
o Î	execu tn and rial-trar	Exar	that initiated events resulting in death) Last c. Due to (or as a consequence of:	Officer of		monins
58760,	icate be executed physician and s the burial-transit	edical	d	•		
9 X C	death certific attending p					23d. Date of delivery
Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months?  1	3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
ds, P	uires that the de signed by the a ld be detached f	by	$T = (1 (1 1 1) \dots 1)$	e underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death? s 2≝No 3 ☐ Probably 4 ☐ Unknown
eco	law require as been się 2 should t	Completed	J		24a. Was an	
Ť	sician; The law s certificate has l irector, page 2 s	Com			perform 1 Yes 2	death?  No 1 Yes 2 No
∠it	sician s certifi irector	o Be	25. Was case referred to medical examiner?	Other:	h (Check only one	
Division or	iding Phys th. : After this ( funeral dir		OT Manager ( Day 1)	e of 28c. Injury at	28d. Describe ho	nce 6 □Other (Specify) w injury occurred
Siol	ttendir leath. tor; Af the fu	catic	2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury - 4t home farm	M 1 ☐ Yes 2 ☐ No	006 1 + /04-	and and Alicenters on Charle Courts Alicenters
	il or Attend after death. I Director: A	Certification:	4 Homicide determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town,	eet and Number or Rural Route Number, , State)
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	ledical C		eath occurred at the time, date and place, r investigation, in my opinion, death occur	and due to the ca red at the time, da	use(s) and manner as stated. ate and place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
)			Stullivan, mD	1062242	-	10/10/0
	1940		30, Name and address of person who completed cause of death (Item 23a) (Typ. Su2dn wl Sullivan AAM)	C 2001 Medi	cal Pa	hway Annualis,
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 1 2 2007  32 Registrar's Signature	South )		

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 12:30 PM Vincenza С. Lottero October 0 13 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Days Months 1 □ M 2 X 88 024-07-1648 Jan. 9,1919 MA Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location a or 28a-f show be notified at 10a. State 1 ☐ Yes 2 No Director MD Gaithersburg Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 20877 333 Russell Avenue United States ral", or items 23a Examiner must b permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must once. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Specify: White 3 K Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Treasurer Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vincenzo Cannariato Josephine Cannata 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Janet M. Lottero / Daughter P O Box 913, Washington Grove, MD 20880 20b. Place of Disposition (Name of cometery, crematory or other place)
Knollwood Memorial Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) October 17 2007 Canton , MA Park Cemetery 21. Signature of Funeral Service Consee 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 1RACY Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Severe Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🕅 No 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 📆 No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes Be 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No 2 in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sayed Eisayyad, M.D., 9715 Medical Center Drive, Rockville, MD 20850 32 egistrar's Signature 31. Date filed (Month, Day, Year) State 15 2007 Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

Amend Item 7 Spar fb. 2873 11/06/07dhb 11/07/07 and Mental Hygiene
Amend Item 21 per fb, 8872, 10/29/07dhb

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 Landers Maureen Α. 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore osedale Hospita . Age (In yrs. last birthday) if Under 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1□ M 2□ F 63 Director 216–42–1215 05/17/1944 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show "natural", or Items 23a or 28a-f shovedical Examiner must be notified at 1 □Yes 2 □No MD **Baltimore** Director Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 414 Cedar Avenue 21221 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Linders Mauree Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: White 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 ho popartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumattc event, the Medical I Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Honemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gregory McMullen Anita A. Langendorfer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith A. Landers, Sr.-Husband 414 Cedar Avenue, Essex, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/23/2007 Bayview Crematory Baltimore.MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. Michael Marzullo per dvr 6009 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner onar if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): and Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the a should be detached to 9 Tilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Onknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No reriphera 24a. Was an page 2 s autopsy performed? Yes 2 No certificate or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 1 Inpatient 28a. Date of Injury (Month, Day 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Harasco MD D-28097 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Ronald AHanasio 9114 Phila Philadelphia Rd. Suite 108 Batto. MD 21237 9114 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

OCT 2 9

			1 - For State Registrar	State of Mar		artmen ertificat			nd Me	, ,	iene	T	34641
ı	Physici /Medic		Decedent's Name (First, Middle, La  LEFFERAGE B. M						1	Date of Dea Month	Day	Year 22 200	3. Time of Death
	Examir		4a. Facility Name (If not institution, giv 1941 Pulaski High	way Box I		N	orth	Location of East				County of Deat	1
	Funeral Director		5. Social Security Number 6. S 213–14–3703 1  Usual Residence of Decedent	ex 7. Age (	In yrs. last birthday	Months	Days	If Under 24 Hours	Min.	Date of Birth (Month, Day B/10/19	Year) 21	Co	thplace (State or Foreign buntry) ryland
Maryland	Maryland a-f ehow	tor	10a. State 10b. County  MD Cecil	1	Oc. City, Town or I								10d. Inside City Limits 1 □Yes 2 No
	th with the 23a or 28	Funeral Director	10e. Street and Number 1941 Pulaski High	way Box I		10f. Zip	Code 2190	1		1	0g. Citiz USZ	zen of What Co	iuntry?
USO urs after dea	hours after death with the Maryland lural; or Itema 23a or 28a-1 ehow al Exercical must be rediffed at	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S. 13	. Was Deced If Yes, spec		spanic Origin, Mexican, I	in? (Speci Puerto Ri	fy Yes or No- can, etc.)		I4. Race - Ame Black, White Specify: Wh	e, etc.
9500-61212	within 72 ane. than "nai	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) Unknown		(Giv	edent's Usua e kind of wor DO NOT us Vestor	rk done d se retired,	ition luring most o	of working			nd of Business/ al Esta	
yland	other vent,	To Be C	17. Father's Name (First, Middle, Last) Unknown Moxley					Unkı	nown	First, Middle, i	.n		
e, Mar	ss 1 and 2 should b of Health and Menis (tem 27 ie merked cother traumatice		19a. Informant's Name/Relationship ( Edith D. Nichols/C 20a. Method of Disposition			Pulas	ski H			ox I, N	orti	Town, State, 2	MD 21901
TIMOL	permit. Pages 1 an Department of Heal Important: if Item 2 eny Injury or other once.		1 Surial 2 Cremation 3 4 Donation 5 Other (Specification 5 Survice Licer) 21. Signature Funeral Service Licer	n)	Bel Air	ematory or o	<sub>ther place</sub> Sa <b>r</b> de	ns   10				cation · City or	Maryland
מ	Department of the control of the con		Cheffrey /	Loul	elce H	arkins	Fun	eral				lta, PA	17314
	Physician /Medical		23a Part 1. The the disease, or come shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)		age ca								Interval Between Onset and Death
certificate be executed ding physician and	rate be executed XX X X I I I I I I I I I I I I I I I I	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	onsequence or).								
	certific Iding p		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d. 23c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at tirn 9 ☐ Unknown	Fetal death 3	□Ectopic pr □ Other (sp				-	2	3d. Date of deli Month	ivery Day Year
cords, r	faw requires that the death as been signed by tha atter 2 should be detached for u	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use conditions are contributing to death but not resulting in the underlying cause given in Part I.							1	othe cause of death?		
ב ב	The fa	Completed							_	24a. Was a autops perform	y	prior to death?	itopsy findings available completion of cause of
Vical	rsician: s certific lirector,	o Be (	25. Was case referred to medical examiner?	Hospital:	2 C S P/Outpotio	2 DO	Othe			th (Check only one)			
	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	F- 9	27. Manner of Death  1					28c. Injury at Work?  1 Yes 2 No			ту)		
tal or Atte	ital or Attures after de rei Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	the Hosp hin 24 hou the Fune mpletely fi	Medical	one) 2 Medical Exam	ystcian. To the best of n niner: On the basis of ex and manner stated	ramination and/or i d.	nvestigation,	in my op	inion, death	occurred	at the time, d	ate and	place, and due	to the cause(s)
	T Will		29b. Signature and title of certifier  30. Name and address of person who  aro S. Hoop  31. Date filed (Month, Day, Year)  OCT 2 9 200	Dopen	und.	290		628	May	efant 2	/O/	signed (Mont)	i, Day, Teal)
	20		Carol S. Hoop	er, M.D.	$\frac{133}{3}$ N. $\frac{1}{3}$	3ridge	_ S	4, 211	Klon	, mo.	219	921	
	Sta Registr	te ar	31. Date filed (Month, Day, Year)  OCT 2 9 200	32. Registrar's	Signature	Sel.							

		•	For State Registrar	State of Ma	aryland				lealth a D <i>eath</i>	and M		giene Reg. No	2 U U I	3464	+ 2
	Dhyaisi		1. Decedent's Name (First, Middle, Last,								2. Date of De Month	ath Da	v Yea	3. Time of Dear	ath
	Physici /Medic	al	Julia Etta D								Oct. 2	23,	2007	1:00 p	) M
7	Examin	er	4a. Facility Name (If not institution, give				4b. City		Location o			4c.	. County of De		
			Mallard Bay Care 5. Social Security Number 6. Sec		e (In vrs la	ast birthday)	If Unde	Ca:	mbrid	0 -	8. Date of Bir	th		rchester Lirthplace (State or Fo	oreion
	Funeral Director			14. 05	80	Yrs.	Months		Hours	8 At-	Sept.	y Year)	1927 M	aryland	a orgin
			Usual Residence of Decedent						ll			, _			
	nylan how		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City L	1
	Sa-f	cto	Maryland Dorches	ter		Wing	gate							1 Tes 2	₹NO
	ith th	Dire	10e. Street and Number	** * * *				p Code				10g. Cit	tizen of What	•	
	a 23a	Funeral Director	2126 Wingate-Bisho			2 42 3		21675		-1-0 (0	-# W N-		US.		
	tem de	- R	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐	,	S. 13. 1	Was Deci	ecify Cuba	ispanic Origin, Mexican	gin? (Spe , Puerto	icify Yes or No Rican, etc.)	)-	Black, W	merican Indian, hite, etc.	
336	urs at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	140		1 🗌 Yes	2 ≥ No	Specify:				Specity:	White	
21215-0036	within 72 hours atter death with the Maryland ene. Than "natural", or itama 23a or 28a-f ahow na Madical Exeminer must bu rudilled al	ted	15. Decedent's Edu	cation	1	16a. Dece						16b. K	(ind of Busine	ss/Industry	
215	thin 7	ple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or !	5+)	life.	DO NOT	use retired	· .	OF WORK	ng				
C	D D = -	Completed	11				He	omema					Own Ho	me	
nd	be filed within 72 hc ital Hygiene. id other then "netul event, ire Medical	Be	17. Father's Name (First, Middle, Last)	D					18. Mothe		(First, Middle		,		
<del>Z</del>		ဥ	Charles Whittingto			[		15.			ysie M			7.0.4.1	
Maryland			19a. Informant's Name/Relationship (7) Ralph Anthony Mill				-				George George			19947	
	1 and		20a. Method of Disposition	5/ 5011	20b. P	lace of Dispo	sition (Na	ame of			ate			or Town, State	
20	80		1 ☐ Surial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		emetery, crer cchest				10	27.200				
Baltimore,	permit. Pag Dapartment Important: I any Injury o		21. Signature of Funeral Service Licens	ee //										c, 11D	
B	permit. Dapartr Importe any Inje		Weller Titur	1- Dun	XII	elel3	irrar )8 Hi	-Bro	mwell t. C	Fun	eral Ho	me,	21613		
			23a. Part 1. Enter the disease or comp shock, or heart failure. List only o	ications that caused	d the death	. Do not ent	ter the mo	de of dyin	ig, such as	cardiac c	or respiratory a	rrest,		Approximate Interval Between	en
	Physician		Immediate Cause (Final disease or condition	Metas		'c. G	1/0	6/20	dar	- 03	moer			Onset and Dea	ath
	/Medical		resulting in death)	Due to (or as			/	7 - 0	CLUCI		, icc			190	
	Examiner		Sequentially list conditions,	b											
q	sit 9d	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	sence of):									
17	be executed sicien and burial-transit	хап	that initiated events resulting in death) Last	c Due to (or as	a consequ	gence of);						-			
8760,	The law requires that the death certificate be executed site has been signed by the attending physicien and page 2 should be datached for use as the burial-transit	dical E		4											
687	ficate g physi	edic	//	u											
Вох	leath certifica attending ph I for use as th	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Testania						23d. Date of	delivery	
B	he deat the atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant a			Other (	pregnancy specify)					Month	Day Yea	ir
P.O.	that the di ed by the datached	Physician/Me	9 Unknown								1				
Ś	rea tha igned be dat		Part II. Other significant conditions co	ntributing to death t	out not resu	alting in the u	inderlying	cause giv	en in Part I	•			/	e to the cause of dea  Probably 4 ⊟Unk	
0	w requir been si should	ted	Hyper Terris	0/0/)		·						185 2	TENO SE	Triodadiy 4 Dollar	
of Vital Records,	hes the	Completed by									24a. Was		24b. Were prior death	autopsy findings ava to completion of caus	ailable se of
alF	ysician: The is certiticate he director, page								.,		1 ☐ Yes	2 1		es 2 No	
<u>¥</u>	Physician: this certition ral director, i	Be	25. Was case referred to medical examiner?	Hospital:				Oth	/		Check only				
	Phys r this ral di	. To	1 ☐ Yes 2 ☑ No  27. Manger of Death	28a. Date of Inju		ER/Outpatier 28b. Time o		JUA	4 - 14		me 5 ☐ Res 28d. Describe			Specify)	
O	ding th. : Atte	itlor	1 Natural 5 Pending 2 Accident investigation	(Month, Da	ay Year)	Injury	м	28c. Injur Wor	rk? Yes 2□	-					
Division	Attending in death. actor: Atterby the fune	fice	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In	jury - At ho	me, farm, st	reet, facto	ory, office						Rural Route Numbe	)F,
Ö	s atta	Certification:	- Citionicae	building, e	ic. (Specif)	()					City or To	mi, Sidi			
	To the Hospitel or Attending Ph within 24 hours atter death. To the Funeral Director: Atter th completely tilled in by the funeral	edical (	(Check only 2 Medical Exam	sician: To the best	of my kno	wledge, deat	th occurre	d at the tir	me, date an	nd place, ath occurr	and due to the	cause(s	s) and manne	r as stated. due to the cause(s)	
	tha thin 2.	Medi	one)	and manner si	tated.									onth, Day, Year)	
	To vit	-	29b. Signature and title of certifier	de			2		e number	00-	2				
			gunton					17	1005	741	2	10	12016	1	
	12		30. Name and address of person who o	ompleted cause of	m h	1 23a) (Type,	Print)	(1	mh	ide	e, M	10	216	6/3	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ture	and s		, 1101	ing	-/ /01				
	Regist		OCT 2 9 200	1 1520 545	and do	1	The state of								

			State of Maryland / Department o		ntal Hygiei	ne 2007	21.61.2
			1 - State Registrar Certificate C		Reg.	NOC UU I	34643
	Physici		Louis Steven mate			Day Year 2007	3. Time of Death
Ŷ	/Medio			n, or Location of Death		20 2007 4c. County of Death	,
and the			Howard Co. General Hosp Color	nbia, m	D	Howan	d
	Funeral		5. Social Security Number 6. Sex 1 M M 2 F 7. Age (In yrs. last birthday) Months Da		Date of Birth (Month, Day, Ye	ar). O Cour	lace (State or Foreign htry) sylvania
Sec.	Director		Usual Residence of Decedent		11/16/	10 Feilli	Syrvania
	arylane show	_	10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits 1 ☐ Yes 2 <b>X</b> No
	he Ma 28a-f	ecto	MD Howard Clarksville  10e. Street and Number 10f. Zip Cor		10-	Citizen of What Cour	
	a or the n	Funeral Director	10e. Street and Number 13717 Spring Dale Drive 10f. Zip Coo			.S.A.	ury:
	death	nera		of Hispanic Origin? (Specify Cuban, Mexican, Puerto Rica		14. Race - Americ	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	y Fu	1 Never Married 2 Married 1 Yes 2 No		an, etc.)	Specify: White,	
21215-0036	hours tural"	ed by	3 ▼Widowed 4 □ Divorced Year or Dates: WW II 15. Decedent's Education 16a. Decedent's Usual Oc	cupation	16h	. Kind of Business/Inc	
215	hin 72 3. an "na Medic	Completed	(Specify only highest grade completed)  (Give kind of work do life. DO NOT use relationship to the life. DO NOT use relationship to the life. DO NOT use relationship to the life.	ne during most of working			,
	filed withir Hygiene. other than ent, the Me	Сол	4 Plant Super	1		ommunicat	ion
Maryland	ntal H ed oth	Be	17. Father's Name (First, Middle, Last)  James Matte	18. Mother's Name (Fi		den Surname)	
IZ.	12 should be f n and Mental t 1 is marked of raumatic eve	၉		eet and Number or Rural Ro		ty or Town, State, Zip	Code)
	1 and 2. Health a tem 27 is		Luana Thompson, Daughter 13717 Sprin	g Dale Dr.,	Clarksv	ille, MD	21029
Baltimore,	ges 1 ar it of Hea if item or other		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State  20b. Place of Disposition (Name o cemetery, crematory or other Susquenanna	place) Oct. 2	28	. Location - City or To	own, State
tim	permit. Pag Department Important: I any Injury o once.		4 Donation 5 Dotner (Specify) IMEMORIAL Garde	ens  2007	. <u>Y</u>	ork, PA	
Bal	permit. Pages 'Department of the Important: If ite any Injury or of once.		: N/ 1/ // / // / / // / / / / / / / / /	nd St., New			-
	·		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.	dying, such as cardiac or re	espiratory arrest,		Approximate Interval Between
N	Physician		Immediate Cause (Final disease or condition resulting in death)  a. 5(5)5				Onset and Death
	/Medical Examiner		Due to (or as a consequance of):	£ (	10.07	2000.14	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	1 from C	7	2/	
3	ecuted Ind transit	Examine	that initiated events	Geo Lyx	a p don	~ ′	
8760,	icate be executed physician and s the burial-transit		Due to (or as a consequence of):	,	9		
687	ficate physis the	edical	d				
Вох	leath certific attending p for use as f	M/us	IF FEMALE: 23b. We decedent pregnant  23c. If yes, outcome pf pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy	anov		23d. Date of delive	ery
	ie deal the att	Physician/Me	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  in the past 12 months?  4 □ Pregnant at time of death 5 □ Other (specif)			Month	Day Year
P.0	res that the de signed by the a be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.	23e. Did tobaco	o use contribute to the	ne cause of death?
Vital Records,	-5 °° 0	ed by			1 ☐ Yes	2 No 3 □ Prot	pably 4 □Unknown
eco	law requas been 2 should	Completed			24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
<u>=</u>		Com			performed	?   d <u>ea</u> th?	2 <b>⊠</b> No
Vita	S S S	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Co			
ō		<u>1</u> کو	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. I	4 La realing Home	5 Residence  Describe how in	e 6 □Other (Specil njury occurred	(y)
ion	Attending Ir death. sctor: After	atio	2 ☐ Accident investigation M	Work? 1 ☐ Yes 2 ☐ No			
Division	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, off building, etc. (Specify)	28f.	Location (Street City or Town, S	t and Number or Rura tate)	al Route Number,
	Hospital 24 hours a Funeral tely filled		29a. Certifier 12Certifying Physician: To the best of my knowledge, death occurred at the	e time, date and place, and	due to the caus	e(s) and manner as s	tated.
	the the the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in rand manner stated.				
	vith		29b. Signature and title of certifier  29c. Lic	ense number	-)   Zad.	Date signed (Month,	20 2007
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1) ) / 5 3	1 0	, 1	0 1 1
	\		(Kassel) Killelucy, n.O- 305 Hosp	ty Drive,	Ofen Bu	urnit, Mel-	2106/
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 2, 9, 2007  32. Registrar's Signature				
	J		UG Z 3 ZUUI AMAMAMAMAMAMAMAMAMAMAMAMAMAMAMAMAMAMAM				

			For State of Maryla State Registrar	-	rtificate of D			leg. No. 2 N N	7 34664		
			1. Decedent's Name (First, Middle, Last)				Date of Dea     Month	th Day Year	3. Time of Death		
	Physicia /Medic	-	BERNARD I. MILLER				OCTOBER	12, 2007	8:45 P M		
	Examiner  4a. Facility Name (If not institution, give street and number)				4b. City, Town, or L	ocation of Death		4c. County of De	ath		
			SPRING HOUSE ASSISTED LIVING		BETHE		1		TGOMERY		
	uneral irector		5. Social Security Number 053-14-1419 6. Sex 1 № 1 № 1 № 1 1 № 1 1 № 1 1 № 1 1 № 1 1 № 1 1 № 1 1 № 1 1 № 1 1 № 1 1 № 1 1 № 1	yrs, last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day 03 / 21 / 19	, Year)	irthplace (State or Foreign Country) W YORK		
yland	at		Usual Residence of Decedent  10a. State 10b. County 10c.	. City, Town or Lo	cation				10d. Inside City Limits  12 Yes 2 □ No		
Mar	a-f st ffied	형	MARYLAND MONTGOMERY B	ETHESDA							
h the	half year than "natural", or items 23a or 28a-f show cother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ie	10e. Street and Number		10f. Zip Code			10g. Citizen of What 0	Country?		
th Wi		Funeral Director	5908 BRADLEY BLVD			20814		U.S			
dea	ems er mi	ner	11. Marital Status 12. Was Decedent Ever in Armed Forces?	in U.S. 13.	Was Decedent of His If Yes, specify Cubar	panic Origin? (Sp n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.		
within 72 hours after death with the Maryland	al", or ite	by Fu	1 ☐ Never Married 2 ☐ Married 1 🏋 Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩		1 ☐ Yes 2√2 No	Specify:		Specify:	WHITE		
72 hours	"nature edical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give life.	dent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of wor	king	16b. Kind of Busines	Business/Industry		
withir 6	and mental hygiene. Is marked other than aumatic event, <u>the Me</u>	臣	Elementary/Secondary (0-12) College (1-4or 5+)		ROOFER			ROOFI	NG		
led L	nt, th		17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle,	Maiden Surname)			
d be file	ed o	Be c	NATHAN MILLER			DOROTHY	BROWN				
should I	teen 27 is marke other traumatic	ဍ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a	nd Number or Ru	ıral Route Numbe	er, City or Town, State	, Zip Code)		
	27 Is r r traur	31 (3	SHARON BERZOFSKY/DAUGHTER		BRADLEY B				20814		
1 and	em 2 ther			Ob. Place of Dispo	osition (Name of	1	Date I	20c. Location - City			
Dailling	perimit. Fages Fam Department of Heal Important: If item 2 any Injury or other once.			EW MONTE	matory or other place FIORE CEM	TRY 10/1	7/2007	FARMINGDAL	E, NEW YORK		
permit.	Importa any Inj		21. Signature of Kuneral Service Licensee	D	2. Name and Addres: DANZANSKY — 170 ROCKV	GOLDBERG	MEMORIA	AL CHAPELS	, INC. YLAND 20852		
//\	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):								
os/ou, icate be executed	to the Hospital or Attending Prysician: The taw requires that the or aftir or intrate be executed within 24 hours after death. Within 24 hours after death this certificate has been signed by the attencing physician and To the Funeral Director. After this certificate has been signed by the attencing physician and completely filled in by the funeral director, page 2 should be detached for us as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cruse. Enter Unity in Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a column of the column of t								
d ath certif		by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions contributing to death but no	Fetal death 3[ e of death 5[	□Ectopic pregnancy □ Other (specify) underlying cause give		23e. Did t		delivery Day Year  to the cause of death?		
I Kecords, The law requires the		Completed					24a. Was	an 24b. Were prior ormed?	autopsy findings available to completion of cause of		
VITAI	ortifica ctor, I	Be C	25. Was case referred to medical examiner?				ath (Check only o	one)			
Jr V	his ce I direc	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ER/Outpatie		4 Williamsing i	7	idence 6 Other (S	(pecify)		
ا ا اع ود	n. After thi funeral		27. Manner of Death 1 □ Natural 5 □ Pending 28a. Date of Injury (Month, Day Ye	28b. Time of Injury	Worf		28d. Describe	how injury occurred			
JIVISION OF 1 or Attending Phys	Attendin death. sctor: Af	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined building, etc. (Specify)  2 Accident 1 Yes 2 No  M 1 Yes 2 No  28f. Location (Street and Number or Rural Route City or Town, State)								
5 5	afte	ert	Torridae								
Hospite	lo the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Physician: To the best of m (Check only one) 2 Medical Examiner: On the basis of examiner and manner stated	amination and/or i	ath occurred at the tin investigation, in my o	me, date and place opinion, death occ	e, and due to the curred at the time	cause(s) and manne , date and place, and	r as stated. due to the cause(s)		
the	within 2  To the I  complet	Med	29b. Signature and title of certifier		29c. License	e number		29d. Date signed (M	onth, Day, Year)		
P	Vaiti Con				Dani	( > 1 ) 11		10/1	Cols		
2	5		30. Name and address of person who completed cause of death	ı (Item 23a) (Type	DOD Medical	03224	\	2/ 1/. 1	^		
			31. Date filed (Month, Day, Year) 32 pegistrar's	7c7 Signature	1140161	verte 1	ine (	. v.14, v	٧)		
	St Regist	tate trar	OCT 15 2007	B. A.	medi						

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Burt I. Feldman, M. D. 3305 N. Leisure World Blvd., Silver Spring, Maryland 20906 . Registrar's Signature 31. Date filed (Month, Day, Year) 15 2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D23958

29d. Date signed (Month, Day, Year)

October 11, 2007

			1 - For State Registrar		State	of Maryl		partment of Prtificate of			Mental H	lygiene Reg. No	1007	34646
	0		1. Decedent's Name (	First, Middle	, Last)						2. Date of	Death		3. Time of Death
	Physici /Medi		Marjorie	Batts	Mann						Octob	er 3,	200 <sup>7</sup>	6:25 P M
	Examir		4a. Facility Name (If no		•			4b. City, Town,	or Location	on of Death		4c.	County of Death	
			Caroline	Home	For Hosp	ice		Dent					Carolin	e
	Funeral Director		5. Social Security Num 132–26–9552		6. Sex 1 ☐ M 2 💢 F		rs. last birthda 1 Yrs.	y) If Under 1 Yea Months Days		der 24 Hrs. 's Min.	8. Date of (Month, Feb.	Day, Year)		place (State or Foreign intry) Jersey
	P .		Usual Residence of De								1200	11,10	30 110 11	ocibey
	anylar show	_		0b. County		10c.	City, Town or	Location						10d. Inside City Limits
$\langle \rangle$	8a-f	Directo		Caroli	ne		Pre	ston						1 Yes 2X No
ζ .	vith th	Dic	10e. Street and Number					10f. Zip Code				10g. Cit	izen of What Cou	intry?
5	23a		22944 Lyn	0aks					1655				USA	
	is 1 end 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If health and Mental Hygiene. If marked other than "naturel", or iteme 23s or 28s-f ehow other traumatic event, its Madical Examiner must be notified at	Funeral	11. Marital Status 1 ☐ Never Married	2M Marn	Armed F	cedent Ever in orces? 2 X No	1 U.S. 13	I. Was Decedent of If Yes, specify Cu	Hispanic ban, Mexi	Origin? (Sp can, Puerto	ecify Yes or Rican, etc.)	No-	<ol> <li>Race - Amer</li> <li>Black, White</li> </ol>	
8	or', or	by	3 Widowed 4 (		If Yes, G Year or I	ive		1 ☐ Yes 2X No	Spec	rity:			Specify:	Vhite
21215-0036	72 ho	Completed	15	5. Decedent	s Education	,	16a. Dec	edent's Usual Occi	upation			16b. Ki	ind of Business/la	ndustry
21	thin 7	npie	Elementary/Seconda		Ť , , , , , , , , , , ,	(1-4or 5+)	life	re kind of work don DO NOT use retir	e during ri 'ed)	nost of work	ang			
ณ	filed will Hygien other the	Con			4		Reg	istered ]	7				lospital	
בַ	be fil htai H od oth	Be	17. Father's Name (Fir		,				18. Mo	other's Name	e (First, Midd	lle, Maiden	Sumame)	
Maryland	should nd Men marke umatic	2	William Au								ie Buc			
ā	12 sho		19a. Informant's Name					ling Address (Stree						p Code)
	1 end 1ealth bm 27 ther tr		Dalton L.  20a. Method of Dispos		Husband	120	2294	4 Lyn Oal	ks Dr					
Baltimore,	Pages nent of P int: if Ite		1 XBurial 2 □ C	Cremation			cemetery, ci	ematory or other pl	ace)	¦ '	Date	20c. Lc	ocation - City or T	own, State
들	it. Printment		4 □ Donation 5   21. Signature o Funer			Ur		shington			/2007	Hur	lock, Ma	ryland
B	permit. Pages Department of Important: if It any injury or o		21. Signature y union		3/	llu	) / Z	22. Name and Add eller Fur .O.Box 20	iera <u>l</u>	Home	, 106	Main	Street	
		-	26a, Part1. Enter the	disease, or	complications that	caused the d	eath. Do not e	nter the mode of dy	una. such	as cardiac	ew_Mar	ket,	MD 2163.	Approximate
	2hveisien		Immediate Cause (Fin		inly one cause on	each line.		/ 1						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		a	(or as a cons	Ver	can	er					1 sacrys
ı	Examiner				20010	(or as a cons	and M	Canc	n('0	~				
		Jer	Sequentially list condit if any, leading to imme cause. Enter Underlying	ediate	b. Due to	(or as a cons	equence ot):	201 (10		,				
	cuted nd ransi	Examin	Cause (Disease or injuthat initiated events	ıry	c									
Ď.	e exe ien ai urial-t		resulting in death) Las	t	Due to	(or as a cons	sequence of):							
8/60	cate be executed physicien and the burial-transit	dical		,	d									
ο ×	ertific fing p	· o	IF FEMALE:										1	W. 19.
X P	death certifi e attending I d for use as	ian/	23b. Was decedent pro in the past 12 mg			birth 2 F	etal death 3	Ectopic pregnance	су			2	23d. Date of deliv Month	ery Day Year
o i	by the detection	Physician/M	1 □ Yes 2 □ N 9 □ Unknown	o	4 □ Pregi	nant at time o	of death 5	Other (specify)		<u> </u>		-		52,
<b>.</b>	88 ≅	H.	Part II. Other significa	nt condition	s contributing to d	leath but not	resulting in the	underlying cause g	iven in Pa	rt I.	23e. Di	d tobacco u	se contribute to t	he cause of death?
Hecords	requires een sign hould be	d by						, , ,						bably 4 Unknown
ទូ	≥ ₽ ।	ete		-							24a, W	/ /	24h Wara aut	none findings available
9	0 - 6	ompleted							·		au	topsy rformed?	prior to co	opsy findings available ompletion of cause of
_	ician: The certificate rector, pag	O	25. Was case referred	to medical		1.17			ae Bl	nan of Doots	1 Yes	-/-	1 🗆 Yes	2□ No
<b>&gt;</b>		0	examiner? 1 ☐ Yes 2 X No		Hospital:	Inpatient 2	☐ ER/Outpatio	ent 3 DOA O					Other (Specia	عبد ٢٠٠٨ م
		L.	27. Manner of Death		28a. Date	of Injury oth, Day Year					28d. Describ			"TIOSPICE
<u>o</u>	5 . 7 3	atio	1 Natural 5	Dending investiga		iiii, Day 19ai	) Injury		onk? ]Yes 2	□No				
	er de recto	ertification:	3 ☐ Suicide 6	Could no determin	of be 28e. Place	e of Injury - A	t home, farm, s	treet, factory, office				(Street and		al Route Number,
5	spital or Al ours after o teral Direc filled in by	O		/										
	Fu h	edicai	29a. Certifier 1 (Check only one)	Certifying Medical E	Physician: To the xaminer: On the band man	p best of my leasis of examiner stated.	nowledge, dea ination and/or	th occurred at the t nvestigation, in my	me, date opinion, d	and place, leath occurr	and due to the	e, date and	and manner as s place, and due t	stated. o the cause(s)
1	vithin 2 To the complet	Me	29b. Signature and title		11.			29c. Licen					e signed (Month,	
					///			DI	do	271		10	15/0	7
		-	30. Name and address	of person w	ho completed caus	se of death (I	tem 23a) (Type	Print)	w	/ 1			10	
			David C. H	alvers	son, M.D.	, 8221	Teal	Orive, Su	ite :	302, I	Easton	, MD :	21601	
	Sta		31. Date filed (Month, I		and the second second	Register's Sig	nature							
	Registr			uci !	0 2007	The same of	24 1	Soll						
UHM	H 17 Rev 1/20	01				7		0						

DHMH 17 Rev 1/2001

07-0	7746	

evin Lenoa ive	•	State 0  1- For State Registrar	f Maryland / Depar <i>Cert</i>	tment of dificate of		ivientai n		g. No.	200	7 3464
Physici	an/	Decedent's Name (First, Middle,Last)					Date of Death     Month     October 4,	1	Year	3. Time of Death 0810 hrs
ledical Exami	ner	Kevin Lenod New 4a. Facility Name (if not institution, give s		14	b. City, Town, or L	ocation of Death			anty of Death	00101113
		Doctors Community Hospita			Lanham			Princ	ce George	's
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min	_	`	Foreign	hplace (State or n untry)Germany
	1	Usual Residence of Decedent			<u> </u>		Ψα19 12	, 101		
ow any		10a. State 10b. County Maryland Charles	La Pl	Town or Location	on					10d. Inside City Limits 1 X Yes 2 No
daryland 28a-f show 1 at once.	ctor	10e. Street and Number			10f. Zip Code		10	g. Citizen o	of What Coun	
ith the Maryland 23a or 28a-f sho notified at once	Director	318 Goose Creek Dr	ive		20646			USA		
and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene.  tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status  1 Never Married 2 X Married	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 X No		s Decedent of Hisp es, specify Cuban,			'	White, etc.	can Indian, Black,
s after c ral", o	by F		Yes, Give Year or Dates:		Yes 2 X No				cify. Blac	
2 hour: "natu	eted	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	College (1-4 or 5+)		t's Usual Occupationst of working life. I			166. Kina	of Business/Ir	ndustry
036 vithin 7 ene. er than Medica	ompleted		2	Route S	ales Dri				nol Bev	verage
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, Last)  Morris Newby			L	8.Mother's Nam ernadee	e (First, Middle, M n King	laiden Sum	iame)	
212 ould be d Ment s mark	To B	19a. Informant's Name/Relationship (Typ	e, Print )		Address (Street	and Number or	Rural Route Num			, Zip Code)
MD and 2 sh salth an em 27 i		Shaunta L. Newby/Sp 20a. Method of Disposition			ose Creel		Plata,M		646 ation - City or	Town State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin		1 X Burial 2 Cremation 3	Removal from State C	rematory or oth	er place)		.13,2007		•	
altim mit. Pa partmer portant		Conation 5 Other Specify: 21. Signature of Funeral Service License			ame and Address					
		1	Md. #278							inia23430 Approximate Interval
Physician /Medical		23a. Part I. Enter the disease, or complic failure. List only one cause on each			ie mode or dying, s	such as cardiac	or respiratory arre	SI, SHOCK, (	ornean	Between Onset and Death
xaminer			ue to (or as a consequence of)							
	e.	Sequentially list conditions,	eep Venous Thrombos ue to (or as a consequence of)							
0	Examin	cause. Enter Underlying Cause (Disease or injury that initiated	ue to (or as a consequence of							
outed nd transit		events resulting in death) Last  d.	re to (or as a consequence or,	)·						"
60, ate be executed hysician and te burial - transit	Medical		amended #28fperMF10/16/07	7.BMW.Mc	ზ					
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth	nancy	tal death 3	Ectopic pregn	ancy	23d. Da Mor	ate of delivery	y Day Year
Box 687; death certific	Physician/I	1 Yes 2 No 9 Unknown	Pregnant at time of dea	ath 5 Oth	ner (Specify)					
O. B at the de 1 by the tached i		Part II. Other significant conditions		sulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
rds, P.O. v requires that the s been signed by to	ed by								o 3 Prot	
of Vital Records, ng Physician: The law require After this certificate has been si neral director, page 2 should b	Completed	·					24a. Was autop			utopsy findings available completion of cause of
		25. Was case referred to medical			26 Plans	of Death (Check	1 ✔ Yes		1 🗸 Ye	es 2 No
of Vital Recing Physician: The After this certificate funeral director, page	o Be		spital: 1 🗸 Inpatient 2	ER/Outpatient		Other:		Residence	6 Other	r:
<b>-</b> = . ` =		27. Manner of Death	28a. Date of Injury (Month, Day Year) Sep 28, 2007	28b. Time of I		y at Work? es 2 No	28d. Describe I Back injury			ems
Division rs after death. al Director: /	icati	2 Accident Investigation	28e Place of Injury - At ho	ome, farm, stree			28f. Location (\$	Street and I	Number or Ru	ural Route Number, City
Div pital or cral Di	Certification:	3 Suicide 6 Could not be determined	(Specify) Wine/Beer	Distributor		85	or Town, S	tate 881	S. PICK	MAlexandria,V
Division  To the Hospital or Attent within 24 hours after death To the Funcral Director: completely filled in by the	Medical (	one) 2 Medical Examiner:	n: To the best of my knowledg On the basis of examination ar and manner stated.	ge, death occur nd/or investigat	red at the time, dation, in my opinion,	te and place, an death occurred	d due to the caus at the time, date	e(s) and m and place,	anner as stat and due to th	ted. ne cause(s)
	Me	29b. Signature and title of certifier	/ Stated.		29c. License				-	onth, Day, Year)
0 10		(arol )	talla	M	O.C.N	л.Е. 		Octobe	er 5, 2007	
_					Street, Baltimo	ore, MD 212	01			
S Regis	tate trar	31. Date filed (Month, Day Year) 200	32 Registrar's Signatu	? Apre	de					

Certificate of Death

Registrar

1 6 2007

State of Maryland / Department of Health and Mental Hygiena State Amend Item 23a per dr., g873, befold And bo Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** eborn rice etabel /Medical 4a. Febility Name (If not institution, give street and number 4b. City, Town or Location of Death 4c. County of Death **Examiner** AliSburg Hers HeAa COMICO HOS enter If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 ☐ M 213FF Yrs. Director 212-66-1212 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28e-f ehow treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Wicomico MARCHAWA XUANLIED 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō KORO 'naturel', or Items 23a USA COKE 2.1856 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes Give 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than . Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 09 1) omestic NONE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be INGER Nola LAWRENCE ANIE ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addre s (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steugis Mother Kd. 20b. Place of Disposition (Name of cometery, crematory or other place) WOLA NANTICOKE Sundico, other 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State CEMETERY 10-18-07 GUANTICO MARKINA 4 □ Donation 5 □ Other (Specify) UANTICO eny injury 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8 21 WEST POI ladys B. Stewar SEWAR YUNERAI HOME SALISBURY, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he in failure. List only one cause on each line. Immediate Cause (Final disease or condition Encephalopathy du Due t (or as a consequence of): 3 days **Physician** due to end stage renal resulting in death) /Medical Examiner Melli inbetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner lotted death certificate be executed arterio-venus and Due to (or as a consequence of): burial. Box 68760, the attending physician 3 days Physician/Medical the as IF FEMALE: use 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 5 Other (specify) P.O. 1 1 ☐ Yes 2 No detached 9 Dunknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Completed peeu 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Inpatient ပ 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After or Attending Injury 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0066064 e, D.O. 30. Name and address of person who complet a cause of death (Item 23a) (Type, Print) HOSPITAL CENTER DEER GUNSALVES salisbury, MD 21842018 HEAD 31. Date filed (Month, Day 32. Fistrar's Signature Year) 2 State Registrar

DHMH 17 Rev 1/2001

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Armida I. October 12, Racedo 2007 7:40 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care-Bethesda Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | 11 Hours | 12 Hrs. | 13 Hrs. | 14 Hrs. | 15 Hrs. | 16 Hrs. | 16 Hrs. | 17 Hrs. | 17 Hrs. | 18 Date of Birth (Month, Day Year) | 17 Hrs. | 18 Date of Birth (Month, Day Year) | 18 Hrs. | 18 Date of Birth (Month, Day Year) | 18 Hrs. | 18 Date of Birth (Month, Day Year) | 18 Hrs. | 18 Date of Birth (Month, Day Year) | 18 Hrs. | 18 Date of Birth (Month, Day Year) | 18 Hrs. | 18 Date of Birth (Month, Day Year) | 18 Hrs. | 18 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1909 1 ☐ M 2 🗗 F 578-70-5222 98 Colombia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3614 Peartree Court 20906 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Marned Yes 2 No Specify: Colombian White Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jose A. Vergara Mercedes Olacirequi ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfredo Racedo/ Son 3614 Peartree Court, #33, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State October 16 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee Francis Collins Funeral Home Inc. Simo 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. After the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Advancec Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physicien and for use as the buriat-transit Due to (or as a consequence of): Physician/Medicai IF FEMALE 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Cher (specify) 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No has le 2 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ္ရ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No I Director: 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours a To the Funeral ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier? 29d. Date signed (Month, Day, Year) DE062435 Media Carle Dr. Rockville, MD 70850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EISAYYAD 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

5 2007

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-07980 State of Maryland / Department of Health and Mental Hygiene Kevin Michael Ryan 1- For State Certificate of Death Req. No Registrar 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 1038 hrs October 13, 2007 **Medical Examiner** Kevin Michael Ryan 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Sinai Hospital N/A If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birtholace (State or 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** oreian Hours Months Days Director 220 23 0808 05/05/1989 Country) MD 1 X M 2 F Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Yes 2 X No s 23a or 28a-f show a notified at once. Columbia MD Howard e, MD 21215-0036
I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.
Health and Mental Hygiene, "natural", or items 23a or 28a-f short reammaite event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10705 Judy Lane 21044 USA 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married Armed Forces' Yes White Yes 2 X No specify: Widowed Divorced If Yes, Give Year Specify. ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Student Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles A. Ryan Angela D. Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Angela D. Ryan/Mother 10705 Judy Lane Columbia, MD Department of Health an Important: If item 27 injury or other trauma 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition timore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Pages 1 10/18/2007 Union Cemetery Spencerville, MD Donation 5 Other Specify. 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pk. Ellicott City, MD Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line M ical Death a. Head and Chest Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examiner couse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed Physician/Medical ysician a UNPENDED X #28e,perME,g872, 10/31/07 TT Box 68760 23d. Date of delivery ding physe as the b IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 2 Yes 2 ✓ No 3 Probably 4 Unknown σ. Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has 2 st The law death? performed? 1 🗸 Yes No ✓ Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Be Division of Vital Other-Hospital: 1 ✓ Inpatient 2 DOA Nursing Home 5 Residence 6 FR/Outnatient 3 this 1 Yes 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 28a. Date of Injury 27. Manner of Death Certification: Oct 12, 2007 Pedestrian struck bv autos 0158 hrs Natura Yes 2 V No Pending within 24 hours after death.

To the Funeral Director: Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) Hillen Road / Lake Drive , Towson, MD determined (Specify) Readway Roadside Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certile 83 October 15, 2007 O.C.M.E. on wy completed death liem 23a) 30. Name and address of p OCS

Registra

Mary G. Ripple MD.

31. Date filed (Molun Day, Year) 2007

Deputy Chief Medical Examiner

32. Registrar's Signatur

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Brown Metcalfe Roe Jr. October 2007 11:30 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Woods Center Cambridge Dorchester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □XM 2 □ F Director 220-32-9897 1935 14, Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show notified at Dorchester 1XYes 2 No MD Director Cambridge filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or liner must be r ò 525 Glenburn Avenue 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 If Yes, Give 1956-59 1 ☐ Yes 2 ☐ No Specify: þ Specify: white 3 ☐ Widowed 4 🕱 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) fuel distributor president 12 .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant; If item 27 Is marked other t llury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Brown Metcalfe Roe Barbee Humphrevs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 Is any Injury or other trau Brown M. Roe III son P. O. Box 16, Galena, MD altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Sudlersville Cemetery 10/13/07 Sudlersville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. An W) 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Verro degenerative ? Physician las /Medical Due to (or as a consumence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buris IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes ✓ No 24a. Was an cate has I autopsy performed? Yes Hospital or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Atter t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

YOW/ey

31. Date filed (Month.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 7 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Rideout **Physician** 0239 October 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital nemorial aston Talbox 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** 214-54-5691 Hours 1 □ M 2 😿 F Months 1936 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 'natural", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director hodesdale 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Forest Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Mo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Sewing Factory Seamstress Department of Health and Mental Hy Important: If them 27 is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Rhodesdale, MD Maiden Forest Rd. Arneda 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 10/13/07 Rhodesdale, MD. 4 Donation 5 Dother (Specify) Reids Grove Cometery 21. Signature of Funeral Service Licensee Henry Funeral Home, P.A. 510 Washington St. Cambridge, MD, 21613 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) bowel **Physician** Obstruction weeks /Medical Due to (or as a consequence of): Examiner MONT Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last for as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2500 certificate 1 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 No 1 [A]npatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 ☐ Homicide To the Hospital 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)
OCT 1

32. Figistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Riggin Brooklyn Nicole October 2007 10 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wiconica egional Medical reninsula If Under 1 Year | If Under 24 Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2**X** F n/a Director 10/10/2007 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 TXNo Funeral Director Maryland Womerset Princess Anne 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with a Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or any Injury or other traumatte event, the Medical Examiner must hen. 21853 USA 30555 Bardwell Drive 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No white þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a n/a n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amy Lynn Shanks ဝ William Mark Riggin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 30555 Bardwell Dr., Princess Anne, MD 21853 Amy Riggin/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 10/12/07 Salisbury, MD Salisbury Crematory 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licepse Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 QA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each live. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading terminal cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. the attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 ☐ Other (specify) s been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 [ Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Injury 1 Natural 2 Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation death. irector A 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide efter To the Hospital o within 24 hours aff 1 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) re and title of certifier. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signati address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month Day)

Carrollst

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1	For State C	of Maryland / De	epariment of F Certificate of			eg. No. 200	7 31.65				
Physicia	n	1. Decedent's Name (First, Middle, Last)  Harry Leo Sl	IMNER			2. Date of Death October	1 <sup>2</sup> 3 <sup>y</sup> , 2007°	3. Time of Death 6:27 A M				
/Medica Examine	r .	4a. Facility Name (If not institution, give street and not Casey House Montgomery F	ımber)	4b. City, Town, o	r Location of Death		4c. County of De					
Funeral Director		5. Social Security Number 017-09-6574	7. Age (In yrs. last birthe	Months   Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth Apr. Bay,	Year 17	Birthplace (State or Foreign Country) EW York				
land ow	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location				10d. Inside City Limits				
e Mary Ba-f sh tiffied	cto	Maryland Montgomery	Sil	ver Spring			0g. Citizen of What	1 ☐ Yes 2 No				
3a or 28	Dire	10e.Street and Number 415 Branch Drive		10f. Zip Code	901	'	United S					
	by Funeral Director	11. Marital Status  1  Never Married  2  Married  1  Never Married  3  Widowed 4 Divorced	aive Army	13. Was Decedent of I If Yes, specify Cub	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No- pecify Yes or No-	Black, W	merican Indian, hite, etc. white				
thin 72 hourse. an "natural" Medical Ex	Completed b	15. Decedent's Education (Specify only highest grade completed	(1-4or 5+)	Decedent's Usual Occu Give kind of work done life. DO NOT use retire	pation during most of work d)	king	16b. Kind of Busines Printing					
filed with Hygien that the the	Con	17. Father's Name (First, Middle, Last)		Printer			Maiden Surname)					
2 should be filed and Mental Hyg Is marked other aumatic event, i	To Be	Benjamin Sumner			Anna Dr							
d 2 sho		19a. Informant's Name/Relationship (Type. Print)		Mailing Address <i>(Stree</i> 1 <b>7 Micah Dr</b>				e, Zip Code) 1904				
permit. Pages 1 and 2 should be Department of Health and Menta Important: If iten 27 is marked any injury or other traumatic ev once.		William Sumner, Son  1907 Micah Drive, Silver Spring, MD 20 20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State 4  Donation 5  Other (Specify)  1907 Micah Drive, Silver Spring, MD 20 20b. Place of Disposition (Name of cemetery, crematory or other place)  Mt. Lebanon Cemetery  10/15/07 Adelphi										
permit. Departm Importal any inju		21. Signature of Fune at Service bicensee	5	Torchander 254 Carro	11 St., N	W, Washi	ngton, DC					
Physician /Medical Examiner		regulting in death)	t caused the death. Do not a each line.  ticemia o (or as a consequence of		ing, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death				
ate be hysicia the bur	edical Examiner	cause. Enter Underlying Cause (Disease of Injury that initiated events	o (or as a consequence o									
death certif e attending d for use as	Physician/Me	230. was decedent pregnant 1 Liv	outcome pf pregnancy e birth 2 ☐ Fetal death gnant at time of death known	3 ☐Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of Month	delivery Day Year				
w requires that is been signed by should be deta	þ	Part II. Other significant conditions contributing to Coronary Artery Diseas	death but not resulting in	the underlying cause g	iven in Part I.		obacco use contribut ⁄es 2□ No 3□	te to the cause of death?  Probably 4 Unkno				
nysician: The law requires that the his certificate has been signed by the director, page 2 should be detached.	Completed	<u>Congestive Heart Failu</u> Dementia	re			24a. Was a autop perfo 1  Yes	sy prior rmed? deat	e autopsy findings availa to completion of cause o th? Yes 2 No				
Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1	□ Inpatient 2 □ ER/Out	natient 3 DOA		ath <i>(Check only o</i>		Specify)Hospice				
ng P	ation: To	27. Manner of Death 28a. Da	te of Injury 28b. T	ime of 28c. Inj			now injury occurred	House				
To the Hospital or Attendi within 24 hours after death. To the Funeral Director A completely filled in by the h	Certification:	4 ☐ Homicide determined bu	ace of injury - At home, far ilding, etc. <i>(Specify)</i>			City or Tov	vn, State)	or Rural Route Number,				
Hospi 24 hour Funer stely fills	edical (	29a. Certifier Check only 2 Medical Examiner: On the one)	the best of my knowledge e basis of examination and anner stated.	, death occurred at the d/or investigation, in m	time, date and place y opinion, death occ	e, and due to the urred at the time,	cause(s) and manne date and place, and	er as stated. I due to the cause(s)				
To the within 2 To the comple	Med	29b. Signature and title of certifier    Whense Williams	v O O		nse number )64615		29d. Date signed (A October					
>		30. Name and address of person who completed c Genevieve Wrobelewski,	ause of death (Item 23a) (	Type, Print) Piccard Dr	ive, Suite	e 100, R	ockville,	MD 20850				
Sta	ite	31. Date filed (Month, Day, Year) 33	Registrar's Signature	harts :								

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H tificate of L			Reg. No.	007	346	56
	Physici	an	1. Decedent's Name (First, Middle, Last)	_				2. Date of De		, 2007	3. Time of I	
	/Medic	al	Ruth Mitchell Stee  4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of D	Octobe		ounty of Death	5:25	AM
	Examin	er	Wilson Health Care			Gaithe		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ontgome		
B <sub>34</sub> .	Funeral Director		5. Social Security Number 6. Sex 578-60-9334	7. Age M 2 ☑ F	(In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, D.	th ay, Year) 18,19	9. Birth Cou 18 Alah	place (State or intry) ama	Foreign
T C	2 A		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City	v Limits
Mond	f aho	tor	Maryland Montgomer	у	Gaithersh						1 🗆 Yes	
4	or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citize	on of What Cou	intry?	
4	238		415 Russell Avenue			20877				ited St		
5-00.50	perim. Tages I and Should be lied within 72 flous also dealt will the waryal periment of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic avant, ite Micrical Examiner must be notified at 00ce.	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	<ol> <li>Was Decedent E Armed Forces?</li> <li>1 ☐ Yes 2 XN If Yes, Give Year or Dates:</li> </ol>	lo	Was Decedent of Hi fYes, specify Cuba 1 ☐ Yes 2 🔀 No		? (Specify Yes or No Juerto Rican, etc.)		1. Race - Amer Black, White Specify: Wh		
3-0036	natura		15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	dent's Usual Occupa	ation	working	16b. Kind	d of Business/li		
7	hen.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	kind of work done of DO NOT use retired,	)	Working	77.1			
א ק	Hygie other t	e Co	17. Father's Name (First, Middle, Last)	4	Tea	cher	18. Mother's	Name (First, Middle	-	cation		
	Mental riked o	To B	Arthur A. Mitchell				Emma	Pearson				
Mary	alth and h		19a. Informant's Name/Relationship (Type William L. Steen-		,	•		#102, Gat				7
ore,	of Height item		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re	moval from State	20b. Place of Dispo	sition (Name of matory or other place OIILAN	e) 00	Date ctober 14.		ation - City or T		
Saltimor	tment tant: I		4 □Donation 5 □ Other (Specify)	$\gamma / \gamma$	Crema	itory		2007	Alexa		Virgin	
מק	Depar Impor		21. Signature of Funeral Service License	Au	_ P	ark Drive	e, Gait	DeVol Fur thersburg	Mary		0877	
	hysician /Medical		23a. Par 1. E et prodisease, or complice shick, or peut faiture. List only one Immediate Cars. (Final disease or endition resulting in death)	ations that caused cause on each in	J	er the mode of dying	g, such as car	rdiac or respiratory a	rrest,		Approximate Interval Betw Onset and D	veen .
	xaminer and parial-transit	dical Examiner	Sequentially list conditions, if any, leadin, to immediate cause. Enter Undertying Cause, (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a	a consequence of): a consequence of): a consequence of):							
The death certif	y the attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23	8d. Date of delik Month		ear
ecords, P.O. Do	n signed b	by	Part II. Dther significant conditions cont	ributing to death bu	ut not resulting in the u	nderlying cause give	en in Part I.		Yes 2		the cause of de	eath?
Tecords,	has bee	Completed	Hypertension					24a. Was		24b. Were aut prior to c death?	opsy findings a ompletion of ca	ivailable iuse of
VILAI TE	(U	e Co	25. Was case referred to medical				00 51	1 Yes	2 Z No	1 Yes	2 No	
a	is cert	0 8	examiner?	spital:	nt 2 ER/Outpatien	t 3 DOA Othe		Death (Check only ng Home 5 Res		□Other (Spec	ifv)	
VISION OF	th. : After this e funeral di	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		28c. Injury Work		28d. Describe			.,,,	
DIVIS	after des	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	iry - At home, farm, str (Specify)	eet, factory, office			Street and wn, State)	Number or Ru	ral Route Numb	ber,
H	within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier Certifying Physic (Check only one)	cian: To the best of er: On the basis of and manner sta	of my knowledge, death examination and/or in- ted.	n occurred at the time vestigation, in my op	ne, date and p pinion, death (	place, and due to the occurred at the time	cause(s) a date and p	ind manner as place, and due	stated. tn the cause(s)	
10 1	withir To th	Me	29b. Signature and title of certifier			29c. License				signed (Month		
Z	20		Puscella Call	atanto	0	041	794		octo	ber 13	3,200	7
			30. Name and address of person who con	hipleted cause of de	eath (Item 23a) (Type,	Print)	p /	Salten	N.M.	m	2082	9
1500	Sta	te	31. Date filed (Month, Day, Year)  OCT 1 5 200	32 Registra	tr's Signature	- I INChU		المرا المحرر	und,	,	00 1	

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) OCT 1 6 2007

S. Gupta, MD

29b. Signature and title of certifier

30. Name and address of person



completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Road

MD 873731

Silver Spring, MD

29d. Date signed (Month, Day, Year)

10-11-2007

20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Tay **Physician** 2007 10:34<sup>A</sup> Kim T. Sweigart /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Howard Howard County General Hospital Columbia Date of Birth (Month Day Year) 9/25/1951 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Vietnam 1 M 2 1 F 56 214-74-5395 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notlfied at Director Ellicott City Md. Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or USA 21042 23a item 27 is marked other than "natural", or items 23s other traumatic event, the Medical Examiner must Funeral 3506 Lakeway Drive Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗆 💢 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ò Specify. Asian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) filed withir Hygiene. College (1-4or 5+ Self Employed Barber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Le Thi Ly 2 Dang Xuan Hach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury or other traun 3506 Lakeway Drive Ellicott City, Md. 21042 Eugene W. Sweigart / husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/15/2007 Catonsville, Md. Metro Crematory Inc. 21. Signature of Puneral Service License 22. Name and Address of Facility Harry H. Witzke's Family F. H. Inc. 4112 Old Columbia Pike Ellicott City, Md. 21043 MOO845 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1 Hour Physician Sersis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner C.Diff Colitis Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) signed by the at d be detached for P.O. 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown Polymyositis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was ап Sigmoid Resection this certificate has al director, page 2 autopsy 1 Yes 2 No or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

nours after death.

neral Director: A
filled in by the fu To the Hospital o within 24 hours aft To the Funeral Di

€67

Yospi Jeremy 31. Date filed (Mont) State Registrar

30. Name and address of person wh

29b. Signature and title of certifier

(Check only

pleted cause of death (Item 23a) (Type, Print)

5755 Cedar Lane Columbia,Md. 32. Figistrar's Signature

DHMH 17 Rev 1/2001

29c. License number

D40469

29d. Date signed (Month, Day, Year)

October 13,2007

			State of State of Registrar	Maryland / Dep 0/16/07,LDB	partment of Fertificate of	lealth and M Death	ental Hygie	2007	34659
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last)  Flossie  S	Pru://s	th City Town	r Location of Death	2. Date of Death Month Sept.	Day Year 6, 2000	3. Time of Death
	Examir Funeral Director	er	4a. Facility Name (If not institution, give street and number 47/8 Diamond Ridge 5. Social Security Number 6. Sex 418-113-2505		White	Plains If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	Charle (ear) 9. Birth Con	
7	se-f show	ector	Usuel Residence of Decedent  10a. State 10b. County  MD Dorchester	10c. City, Town or I	bridg	e			10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
3	deeth with the me 23s or 2 it must be n	Funeral Director	10e. Street and Number  7 / 0 .		10f. Zip Code  2  3. Was Decedent of H If Yes, specify Cuba	6/3 ispanic Origin? (Spe		14. Race - Amel	ncan Indian,
2-0036	filed within 72 hours after deeth with the Maryland Hygiene ther then "natural", or iteme 23a or 28a-f show ther, the Mudical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 3 ☐ If Yes, Give Year or Da	2 12/No etes:	1 ☐ Yes 2 ☐ No	Specify:	16	Specific A	acK
2121	filed within 7 Hygiene. other then "r ent, the Med	e Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-  Tollege (1-  To	40r 5+)	re kind of work done of DO NOT use retired	re S.S		Sewing	Factory
Maryland	12 should be and Mental ris marked c	ToB	Ben Wise  19a. Informant's Name/Relationship (Type, Print)	TWO WITH THE		and Number or Rura	l Route Number, C	OMOM City or Town, State, Z	
altimore, I	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23s or 28s-f show my injury or other treumstic event, the Medical Exprining must be notified at ance.		Bay bay a Thom  20a. Method of Disposition  1 Daurial 2 Cremation 3 Removal from S  4 Donation 5 Other (Specify)	20b. Place of Disp	position (Name of Jematory or other place)  Come to	:e)	oate 20	ic. Location - City or	
Balt	permit. Pag Depertment Important: I eny injury o		21. Signature of Funeral Service Licensee  23a. Part. Enter the disease, or complications that ca	Lewrey 1-	22. Name and Addre	ss Facility LINERAL	Home, N St. Co	P.A.	MD. 21613
£	Physician /Medical Examiner		shock, or heart failure. List only one cause on ea Immediate Cause (Final disease or condition resulting in death)  a	or as a consequence of):	Anael	nia Cancei			Interval Between Onset and Death Months
3760,	4	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	or as a consequence of):					
P.O. Box 68	The law requires that the death certificate be executed tie has been signed by the attending physicien and oage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	int at time of death 5	B Ectopic pregnancy C Other (specify)	,		23d. Date of deli Month	very Day Year
	w requires that been signed by should be deta	ρ	Part II. Other significant conditions contributing to dead Dementia, H			en in Part I.		cco use contribute to	the cause of death?
tal Rec	en: The law itilicate has b	e Completed	25. Was case referred to medical			26 Place of Death	24a. Was an autopsy performe 1 Yes 20	prior to death?	topsy findings available completion of cause of
Division of Vital Records,	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation; To B	examiner?  1  Yes 2  Acident  1  Asaminer of Death 1  Asaminer of Death 28a. Date of (Month) (Month)	patient 2 ER/Outpatient Injury 28b. Time Injury	of 28c. Injur	er: 4 🗆 Nursing Ho		6 X Other (Special injury occurred	Son's residence
DIVIS	spitel or Att. ours after de neral Directe filled in by ti	ai Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place or buildin  29a. Certifying Physician: To the leading to the leadi	of Injury - At home, farm, s g, etc. (Specify)			City or Town,		
)	To the Hospitel of within 24 hours af To the Funeral D completely filled in	Medical	(Check only one) 2 Medical Examiner: On the ba	sis of examination and/or	investigation, in my o	pinion, death occurr	ed at the time, date	e and place, and due d. Date signed (Monti	to the cause(s)
_			30. Name and address of person who completed cause  1/350 PEMBRGOKE	SQUARE,		Rt, MI		603	
	Sta Registi		31. Date filed (Month, Day, Year) 32. Re CT 1 6 207 >	gisar's Signature	books				

DHMH 17 Rev 1/2001

ORIGINAL

		State of Maryland / De	epartment of Health and M	-	-
		POI	Certificate of Death	Reg. No	2007 31660
Dhara		Decedent's Name (First, Middle, Last)		2. Date of Death Month Da	3. Time of Death
Physi /Me	ician dical	Virgii Anstine Seward Jr.		Oct. 4	2007 8:43 a. M
Exam	niner	4a. Facility Name (If not institution, give street and number)  Mallard Bay Care Center	4b. City, Town, or Location of Death  Cambridge	40	: County of Death  Dorchester
Funera	al	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
Directo		214–07–9320 <sup>1</sup> <b>X</b> <sup>M</sup> <sup>2</sup> □ F 88 <sup>Yr</sup>	s. Months Days Hours Min.	(Month, Day, Year, Oct. 21, 1	918 Maryland
and w	9	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of the country 10c. City,	or Location		10d. Inside City Limits
Many Help	ţ	MD Dorchester	Cambridge		1. Yes 2 □ No
death with the Maryland one 23a or 28a-f ehow	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Ci	tizen of What Country?
ath w	rai	304 Academy St., Unit 101	21613		USA
ter de	Fune	11. Marital Status  1 □ Never Married	<ol> <li>Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F</li> </ol>	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
ural', or	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: white
72 hc	Completed	15. Decedent's Education 16a. Deceify only highest grade completed) (6	Decedent's Usual Occupation Give kind of work done during most of working	16b. k	(ind of Business/Industry
within then	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	ife. DO NOT use retired) 7ice president	mo	oving company
d be filed antal Hygi ked other	Be C	17. Father's Name (First, Middle, Last)		(First, Middle, Maider	
Menta Menta Menta mrked	5		Dorothy	Moore	
If E, INELYICATION IN INC.			Mailing Address (Street and Number or Rura	-	
Healther 2		20a. Method of Disposition 20b. Place of D			1613 ocation - City or Town, State
rmit. Pages spartment of portant: If II		1 🗆 Burial 2 🗵 Cremation 3 🗆 Hemoval from State	crematory or other place)  ITY Crematory 10/5/	/07 Sa	lisbury, MD
permit. Pages Department of Important: If ite	SDC9.	21. Signature Funeral Service Licensee	22. Name and Address of Facility Tho		
	ä	I the u's leave	700 Locust St., Can		
		23a. Part I. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final	0.00		Approximate Interval Between Onset and Death
Physicia /Medica	_	disease or condition resulting in death)  a	escular accio	den7	24005
Examine	er				W
be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Lines Unclaying Cause (Disease or injury	):		
be executed ician and burial-transit	Examiner	that intitated events resulting in death) Last Due to (or as a consequence of	);		
0 0 0	cat				
A OO entifica ling ph e as th	Med	IF FEMALE:			
Bath cer attendir for use	Physician/Med	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year
the d	hysic	1 Tes 2 No 9 Unknown 9 Unknown	out out (speeding)		
es that gned t			he underlying cause given in Part I.		use contribute to the cause of death?
w requires the been signed should be	ted	HTN, dementia		1 Tes 2	Probably 4 Unknown
has b	Completed by			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
In: The stifficate for. pa.	ပိ		26. Place of Death	1 Yes 2 No	
ysicia ysicia lis cer	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outp	Other	ne 5 Residence	6 ☐Other (Specify)
offing Phy th.: After this		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Inj	ury Work?	28d. Describe how inju	ury occurred
Witend death ctor: y	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury, At home, farm	M 1 Yes 2 No	28f. Location (Street a	nd Number or Rural Route Number,
al or Atters attended in Director	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Stat	e)
LIVISION OF VITAL NECOLUS, F.O. BOX OR To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edical (		death occurred at the time, date and place, a or investigation, in my opinion, death occurre	and due to the cause(s	s) and manner as stated.  Indicate the state of the state
o the ithin 2 o the omplet	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
F ≯ F 8		Madayen	140059973	10	15/07
		30. Name and address of person who completed cause of death (Item 23a) (T	ypa, Print) e St Cambrid	1 206	
		P (John Son Jobs Branch 31. Date filed (Month, Day, Year) 32. Registar's Signature	e of Cambrid	age the	/
Regi	State Strar	OCT 0-9 2007	Looks		
				1	

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 8, Mildred A. Sykes October 2007 1:23p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 M 2 F 242-36-2414 77 Director July 6, 1930 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 X Yes 2 □ No Director Brunswick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene. Important: I flew 72 is marked other than "natural", or items 23a or any hiury or other traumatic event, the Medical Examiner must be a 21716 U.S.A 1100 Peach Orchard Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No ρ Specify. White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grocery Clerk 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar Lee Nolen ဥ Rosa Lee Hancock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 915 E. D. Street, Brunswick, MD 21716 <u>Diane Scott / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/11/2007 Jefferson, Maryland Pleasant View Cem. 21. Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Home 1100 North Maple Ave., Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ratra corebra Kernmerhage /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ Mo 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 1 No 1 ☐ Yes 1∏ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA ပ 1 Impatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

State Registrar

Medical

31. Date filed (Month, Day, Year) OCT 1 6 2007

29b. Signature and title of certifier

Kai

4 Homicide

(Check only one)

MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7th Street Fredrick

Frederick Mem. Waspital Mudusar

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #5 Per FH G873 11/14/07 ONErtificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** OCTOBEL 2007 Jr. Donald Lee Schul /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Peninsula Regional Medical Center Alishuru /Necomico Date of Birth (Month, Day, Year) 1/06/1972 Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M M 2 □ F 35 West Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Bishopville Director Maryland Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21813 10172 Rabbitt Ridge Lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: δ White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Denco Kitchen Designer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Darlene Marie Theiss Donald Lee Schul Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 10172 Rabbitt Ridge Lane Bishopville,MD 21813 Kristin Schul/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 10/12/07 Salisbury, Maryland Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Holloway Funeral Home PA
501 Snow Hill Rd. Salisbury, Maryland 21804 I Funeral Service Licensee 4. Dompool Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Physician 10 months /Medical Due to (or as a consequence of): **Examiner** Acute rena Sequentially list conditions, if any, leading to infine rate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for do disconnectampe off Examiner Hyperkalenia
Due to (bras a consequence of): The law requires that the death certificate be executed attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9∏Unknown 9 Unknown 23e. Did tobacco use ontribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ director, page 2 should be 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide l 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

18U

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FERNANDO ACIE, M.O. 100 E. CARROLL ST.

State Registrar 31. Date filed (Month, Day, Year) 2 2007



DO041211

10/11/07

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 34663

	1- For State Registrar 1- Power death Name (First Middle Last)										Reg. No.					
Physician/	1	. Decedent's Name (First,		seph S	Schmid	1+	·		•	2	Month	Da	ay Yea	ır	3. Time of 2030 h	
Medical Examine		a. Facility Name (if not ins		_			41	o. City, Town,	or Location	of Death	Octobe	117,	4c. County	of Death		
		2112 Whitehall Ro						Frederick					Frederic			
Funeral Director		. Social Security Number 215-92-3541	6. Sea	M 2F		yrs. last birt +1	hday) Yrs.	If Under 1 Ye Months Da	ays Hours	_	8. Date o May	,	MWDD/YYYY 1966	Foreign	nplace (Sta n Washi ıntry)	ington, DC
8	_	Isual Residence of Decede			1100	City, Town	or Locatio	ın							10d. Inside	e City Limits
yland -f show any once.		MD F	rederi	.ck		oity, rowii	O LOCATIO	Freder				<b>.</b>			1 X Yes	2 No
the Maryland Sa or 28a-f sh otified at one		Oe. Street and Number 2112 White	Hall E	Road, #	‡1A			10f. Zip Code	702			10g.	Citizen of W		itry?	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		1. Marital Status  1. X Never Married 2  3. Widowed 4		12. Was Der Armed F 1 Yes If Yes, Give Yea or Dates:	orces?		If Ye	Decedent of H s, specify Cub	an, Mexicar	n, Puerto F				e, etc.	can Indian, iite	Black,
5-0036 ed within 72 hours aft lygiene. other than "natural" he Medical Examine Completed by		15. Decedent's Education Elementary/Secondary (		y highest gra	de complet 1-4 or 5+)		during mo	s Usual Occup st of working l ivil Er	fe. DO NOT	use retire						t
5-003(ed within tygiene.	1	7. Father's Name (First, M	ddle, Last)						18.Mothe	r's Name (	First, Midd	dle, Mai	den Surname	e)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than event, the Medica	Ronald George Schmidt										ucher					
Dad Parisi	Ronald G. Schmidt/Father /110 Riverdale Road,									Lanha	ım,	MD 20	706			
ore, MEss l and 2 s of Health at If item 27	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)									Date		20c. Location	•			
	1	4 Donation 5 Oth 21. Signature of Funeral Se	er Specify:	_	1	Metro	22. N	an Crem	ess of Facili	tv	24/07	/.	Alexan  739 Ba	1+4	10 m 0 A	TY OP 110
Balt permit Depart Impor injury	1	I lonstan	ree	Has	ch		Gas	sch's E	unera	1 Hor	ne, P	A H	yattsv	ille	, MD	20781
Physician /Medical		23a. Part I. Enter the disea failure. List only one of Immediate Cause (Final dis	ause on ea	ch line.							c or respiratory arrest, shock, or heart  Approximate Interva Between Onset and Death					n Onset and
xaminer		or condition resulting in de		Due to (or as				11) 20000								
le l		Sequentially list conditions f any, leading to immediate cause. Enter Underlying C	1	Due to (or as	a conseque	ence of):										
ted nsit Examiner		(Disease or injury that initial events resulting in death)	ted C.	Due to (or as	a conseque	ence of):										
3760, ficate be executed g physician and sthe burial - transit		X UNPENDED	a	AMENDED	27 . ner/	TE. G872	10/3	0/07 TT		-	-					
ficate be g physic sthe bur	1 2	F FEMALE: 3b. Was decedent pregnal	t in the	23c. If yes,	outcome o	r pregnancy	•	al death	2 Estar	ia prompo	201		23d. Date of		y Day	Year
by the attending the death certification of the attending the distribution of the dist		past 12 months?	Unknown	4 Preg	birth nant at time	af damale		ardeath ner (Specify)		nc pregnar	icy		Wichtin		Juy	7001
). Bc the dea ched for the dea		Part II. Other significant of			nown to death bu	t not resultin	na in the u	nderlying caus	e given in F	Part I.	23e.I	Did toba	acco use con	tribute to	the cause	of death?
P.O es that igned be deta	3			00.10.10.10.10							1	Yes	2 No 3	Prol	bably 4	Unknown
Records, The law requires ficate has been sig		<del></del> -										Was an autopsy				ngs available of cause of
(eco				+							1 !	perform Yes 2	ed?	death? 1 ✔ Ye	es 2	2 No
al R ian: T ctor, p	25. Was case referred to medical 26. Place of Death (Che								n (Check o	only one)						
F Vit	1 V Yes 2 No Injury 28s Date of									Home 5	_	esidence 6 w injury occu		r: Scene		
lon of tending leath.  or: Afte the funer		1 X Natural 5	Pending Investigation	- 3	e of Injury th, Day,Year)	280.	Time or ir	′′ I _	Yes 2		zou. Desc	ille ilo	w injury deca	ireu		
Division of Vital Records, P.O. spital or Attending Physician: The law requires that if hours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach. Contrification: To Re Commisted by P.		3 Suicide 6 Homicide	Could not li	pe 28e. Pla		- At home, f	farm, stree	t, factory, offic	e building,	etc.		tion (Str wn, Sta		ber or Ru	ural Route I	Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans Madical Certification: To Re Commissed by Physician/Medical E.		29a. Certifier 1 Certify	ing Physici I Examiner	an: To the be On the basis	of examina	owledge, de ation and/or	eath occur investigat	red at the time ion, in my opir	, date and p ion, death o	place, and accurred a	lace, and due to the cause(s) and manner as stated. ccurred at the time, date and place, and due to the cause(s)					
F F S E	2	29b. Signature and title of	ertifier	C C					ense numbe	er						ear)
		Patrui ()	11	- Pal	0,0	- ps		O.	C.M.E.		October 18, 2007					
CAR (6)	1	30. Name and address of p Patricia Aronica-F				n (Item 23a) Iical Exar		111 Penn	Street, E	Baltimore	e, MD 2	1201				
Stat	e :				Registrar's	Signatur	R	-	_							
Registra	iΓ	Date filed (Month, Day Year)  OC 2 3 2007  Tieseen 3. Registrar's Signature														

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year 0015 M **Physician** Hompson 2007 october 11 uani /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot memorial Hospital Eastor Easton at If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days **Funeral** 1 □ M 2 1 F Maryland -22 -2528 2/3-22-252 Usual Residence of Decedent Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 1 Ves 2 No a or 28a-f sh t be notified **Funeral Director** 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 2/6/3 death with 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: or items, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner. 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify. 3 ₩Widowed 4 Divorced Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Receptioni HUMan 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cornish 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mailing Address (Street and Number or Hural House Insurance), Only of Toward Street Cambridge, MD: 21613

Toward Name of Date 20c. Location - Pity or Town, State 19a. Informant's Name/Relationship (Type. Print) Yose  $\mathbb{J}$ bowens Method of Disposition 1 Burial 2 Cremation 3 □Removal from State Cambridge, MD. Mid Shore Cremation 10/15/67 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Henky Funeral Home, P. A.

510 Washington Str. Cambridge, MD. 31613

Approximate

Immediate Cause (Fine)

Approximate

Interval Rehuser 4 ☐ Donation 5 ☐ Other (Specify) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UUCa hour Physician /Medical Due to (on a a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed the burial-trar physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 X Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 NO 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Ninpatient 2 ☐ ER/Outpatient 3□ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

Domp

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regetrar's Signature

Abraham

31. Date filed (Month, Day, Year)

	1	State RegistrarAMEND#17perFH  1. Decedent's Name (First, Middle, La	ast)	weis	c Mu	ll-er		1	late of Deat	h Day	2003	3. Time of Death		
edica		Ia, Facility Name (If not institution, gi		WEL	21114	4b. City, Town, o	or Location o		Hober	_	nty of Death	• •		
mine	r	SHADY GROVE ADV		PITAL		ROCKV				MON	TGOME:	RY		
ral	5		Sex 7. Age	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days		Min. (	ate of Birth Mo <i>nth</i> , Day,		Cou	place (State or Foreig intry)		
or	-	331-34-7247 Usual Residence of Decedent		80	115.			Ma	rch 2,	, 1927	Arg	entina		
Ι.		10a. State 10b. County		10c. City, To	own or Lo	cation						10d. Inside City Limit 1 ☐ Yes 2 N		
	Director	MD Montgo	mery		Ge	ermantown	<u> </u>		1.0	On Citizon	of What Cou	·		
		10e. Street and Number 13801 Deakins La	ne			10f. Zip Code 2087	74		'	_	ed St			
	runerai	11, Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13.	Was Decedent of I If Yes, specify Cub	Hispanic Orig	gin? (Specify	Yes or No- n. etc.)		Race - Ameri Black, White			
		1 Never Married 2 Married	1 ☐ Yes 2. 1 N If Yes, Give	10	1	1 ☐ Yes 2 🗓 No		, , , , , , , , , , , , , , , , , , , ,	.,,,			hite		
	ea bà	3 Widowed 4 Divorced  15. Decedent's E	Year or Dates:	1 1	6a. Dece	dent's Usual Occu	pation			16b. Kind of	f Business/Ir	ndustry		
	plet	(Specify only highest gi	rade completed) College (1-4or 5		(Give life.	kind of work done DO NOT use retire	during most ed)	t of working	ľ	Bank				
	Be Completed	Liementary/Secondary (0-12)	5+	·/	]	Banker								
	Re	<sup>17</sup> Jösépne <i>Carlidle</i> wê <del>Sarle Weissmulle</del>	issmuller				1	r's Name <i>(Fir</i> .chaela	ame (First, Middle, Maiden Surname) aela Catura					
ŀ	<u> </u>	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Stree	t and Numbe	er or Rural Ro	al Route Number, City or Town, State, Zip Code)					
Joan Weissmuller					1380	l Deakins	s Lane	, Germ	rmantown, MD 20874					
	1	20a. Method of Disposition 1 ☐ Burial 2 XCremation 3	□Pomoval from State	20b. Place cem	e of Dispo	osition (Name of matory or other pla	ace)	Date	e 20c. Location - City or Town, State					
	1	4 ☐ Donation 5 ☐ Other (Spec	cify)	Metr		itan atory		2007	13	Alexar	Virginia			
Sarlo Weissmuller  19a. Informant's Name/Relationship (Type. Print) Joan Weissmuller / Wife  19b. Mailing Address (Street and Number or Rural Route Number, City of 13801 Deakins Lane, Germantown, Market Sand Deakins Lane,										ţ Dee	eer Park Drive,			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										est,	Approximate			
i		Immediate Cause (Final												
1	- 1		4.0-	Tile .								Interval Between Onset and Death		
		disease or condition resulting in death)	a. Due to (or as	a consequen	Folli	rentar ly					م	Onset and Death		
١		resulting in death)	b.	a consequen	Folls nce of):						۵	Onset and Death		
	niner	resulting in death)	Due to (or as	a consequen	Folls nce of):						۵	Onset and Death		
r	Examiner	Sequentially list conditions, if any, leading to financiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	a consequen	Folls nce of):						م	Onset and Death		
	cal Ex	Sequentially list conditions, if any, feading to interesting cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequen	Folls nce of):						۵	Onset and Death		
	cal Ex	Sequentially list conditions, if any, feading to interesting cause. Enter Underlying Cause (Disease or injury that initiated events	b	a consequent	Following of the control of the cont					Рас		marken		
ľ	cal Ex	Sequentially list conditions, if any, feading to interesting cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	b. Due to (or as b. Due to (or as d. Due to (or as d. 23c. if yes, outcome	a consequent a consequent a consequent	Following of the control of the cont		tubn			Рас	Date of deli Month	marken		
	cal Ex	Sequentially list conditions, if any, reading to interesting cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	b	a consequent a consequent a consequent	Following of the control of the cont	Scular IV	tubn			Рас	Date of deli	mark w		
	Physician/Medical Ex	Sequentially list conditions, if any, feading to interediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions	b	a consequen  a consequen  pf pregnancy 2 ☐ Fetal det time of deat	Following of the second of the	Ectopic pregnan  Other (specify)	cy	Orra -	23e. Did to	23d.	Date of deli Month	ivery Day Year the cause of death?		
	by Physician/Medical Ex	Sequentially list conditions, if any, teading to interest cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  Part II. Other significant conditions  Attal     Challe	b. Due to (or as b. Due to (or as d. Due	a consequen  a consequen  pf pregnancy 2 ☐ Fetal det time of deat	Following of the second of the	Ectopic pregnan  Other (specify)	cy	Orra -	uta	23d.	Date of deli Month	ivery Day Year		
	by Physician/Medical Ex	Sequentially list conditions, if any, feading to interediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions	b. Due to (or as b. Due to (or as d. Due	a consequen  a consequen  pf pregnancy 2 ☐ Fetal det time of deat	Following of the second of the	Ectopic pregnan  Other (specify)	cy	Orra -	23e. Did to	23d. bacco use cores 20XN	Date of deli Month	ivery Day Year the cause of death?		
	Completed by Physician/Medical Ex	Sequentially list conditions, if any, leading to interest cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  Part II. Other significant conditions  Awal Fball	b. Due to (or as b. Due to (or as d. Due	a consequen  a consequen  pf pregnancy 2 ☐ Fetal det time of deat	Following of the second of the	Ectopic pregnan  Other (specify)	cy iven in Part I	0 ma -	23e. Did to 1	23d. bacco use of the state of	Date of deli Month	ivery Day Year  the cause of death? obably 4 Unknown topsy findings availate completion of cause of		
	Be Completed by Physician/Medical Ex	Sequentially list conditions, if any, leading to interreducte cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions  Attal Fball  25. Was case referred to medical examiner?	b. Due to (or as b. Due to (or as d. Due	a consequen  a consequen  pf pregnancy 2 ☐ Fetal detime of deat  ut not resultir	Following in the u	□Ectopic pregnan □ Other (specify) underlying cause g	cy iven in Part I	e of Death  C	23e. Did to 1	23d. bacco use of the symmetry	Date of deli Month  contribute to  lo 3  Pro  4b. Were au  pior to death? 1  Yes	ivery Day Year  the cause of death? tobably 4 Unknow stopsy findings availat completion of cause of		
	To Be Completed by Physician/Medical Ex	Sequentially list conditions, if any, teading to interest cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   25. Was case referred to medical examiner? 1   Yes   2   No   27. Manner of Death	b. Due to (or as. b. Due to (or as. c. Due to (or as. d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown contributing to death birth as contributing to death birth as 200 Members 28a. Date of Injure 28a. Date of Inju	a consequen  a consequen  pf pregnanc; 2   Fetal det time of deat  ut not resultir  ut not resultir	Folly nice of):  no of,  no of	□Ectopic pregnan □ Other (specify) underlying cause g	cy  26. Place ther: 4 No.	e of Death Cursing Home	23e. Did to 1	23d. bacco use of the symmetry	Date of deli Month  contribute to  lo 3 pri  4b. Were au prior to c death? 1 yes	ivery Day Year  the cause of death? tobably 4 Unknow stopsy findings availat completion of cause of		
	To Be Completed by Physician/Medical Ex	Sequentially list conditions, if any, feading to interediate cause. Enter Underfying Cause (Disease or injury that initiate devents resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as. b. Due to (or as. c. Due to (or as. d. 23c. if yes, outcome 1 Live birth 4 Pregnant at 9 Unknown s contributing to death broken bro	a consequen  a consequen  pf pregnanc; 2   Fetal det time of deat  ut not resultir  ut not resultir	Following of the unit of the u	Ectopic pregnan Other (specify) underlying cause g	cy  26. Place ther: 4 No.	e of Death Cursing Home	23e. Did to 1	23d. bacco use of the second s	Date of deliment of the second	ivery Day Year  othe cause of death? obably 4 Unknow utopsy findings availat completion of cause of		
	To Be Completed by Physician/Medical Ex	Sequentially list conditions, if any, feading to infanediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions  Adval Fortile  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death 1   Natural 5   Pending	Due to (or as. b. Due to (or as. c. Due to (or as. d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown s contributing to death birth birth birth birth 28a. Date of Inju (Month, Da.)	a consequent a consequent a consequent pf pregnancy 2   Fetal de t time of deat ut not resultir ut not resultir  ent 2   ER iny y Year)   28	Folly nice of):  noe of): Noe of): Noe of): Noe of): Noe of): Noe of): Noe of): Noe of): Noe of): Noe of): Noe of): Noe of): Noe of): Noe of): Noe of): Noe of): Noe of): Noe of): Noe of)	Ectopic pregnan Other (specify) underlying cause g	26. Place ther: 4 No. ury at ork?	e of Death Cursing Home	23e. Did to 1	23d.  bacco use of the service of th	Date of deliment of the second	ivery Day Year  the cause of death? tobably 4 Unknow stopsy findings availat completion of cause of		
	Certification: To Be Completed by Physician/Medical Ex	Sequentially list conditions, if any, feading to infanediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions  Adval Fortile Significant conditions  Adval Fortil	b. Due to (or as. b. Due to (or as. c. Due to (or as. d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown scontributing to death be contributing to death be 28a. Date of Inju (Month, Date o	a consequent a consequent pf pregnancy 2 Fetal dettime of deat ut not resulting ut not resulting y y Year) 25 ER	Folly nice of):  noe of):	DEctopic pregnam Other (specify) Underlying cause g	26. Place ther: 4 Nu ury at ork?   Yes 2   e	e of Death Cursing Home 28d	23e. Did to 1 Yes  24a. Was a autop. perform 1 Yes  heck onl or 5 Resid  Describe h  Location (S  City or Tow	23d.  bacco use of the symmetry of the symmetr	Date of deliment of the Month  Dontribute to the Month of	ivery Day Year  the cause of death? obably 4 Unknow atopsy findings availat completion of cause of 2 No  cify)  ural Route Number,		
	Certification: To Be Completed by Physician/Medical Ex	Sequentially list conditions, if any, feading to infanediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions  Adval Fortile Significant conditions  Adval Fortil	Due to (or as. b. Due to (or as. c. Due to (or as. d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown s contributing to death birth 2000 Month, Da. lon be 28e. Place of injuicted birth 28e.	a consequent a consequent a consequent pf pregnancy 2 Fetal de time of deat ut not resulting the property of my knowled fexamination	Folly nice of):  noe of):	DEctopic pregnam Other (specify) Underlying cause g	26. Place ther: 4 Nu ury at ork?   Yes 2   e	e of Death Cursing Home 28d	23e. Did to 1 Yes  24a. Was a autop. perform 1 Yes  heck onl or 5 Resid  Describe h  Location (S  City or Tow	23d.  bacco use of the symmetry of the symmetr	Date of deliment of the Month  Dontribute to the Month of	ivery Day Year  the cause of death? obably 4 Unknow atopsy findings availat completion of cause of 2 No  cify)  ural Route Number,		
	To Be Completed by Physician/Medical Ex	Sequentially list conditions, if any, feading to interediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as. b. Due to (or as. c. Due to (or as. d. 23c. if yes, outcome 1 Live birth 4 Pregnant at 9 Unknown contributing to death brack of the contributing to death brack of the contribution be 28a. Date of Inju (Month, Date of the contribution)  28a. Date of Inju (Month, Date of the contribution)  28a. Place of injuding, etc.	a consequent a consequent a consequent pf pregnancy 2 Fetal de time of deat ut not resulting the property of my knowled fexamination	Folly nice of):  noe of):	DEctopic pregnam Other (specify) Underlying cause g  ont 3 DOA of 28c. Inj Wh M 1[ treet, factory, office th occurred at the nvestigation, in my	26. Place ther: 4 No.	e of Death Cursing Home 28d.	23e. Did to 1	23d.  bacco use of the symmetry of the symmetr	Date of deli Month  contribute to lo 3 Pro 4b. Were au prior to c death? 1 Yes  Courred  death of the courred  death of the courred  death of the courred  death of the courred	ivery Day Year  othe cause of death? obably 4 Unknow  utopsy findings availat completion of cause of 2 No  cify)  ural Route Number, s stated. e to the cause(s) th, Day, Year)		
	Certification: To Be Completed by Physician/Medical Ex	Sequentially list conditions, if any, feading to interesticate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Bue to (or as. b.  Due to (or as. c.  Due to (or as. d.  23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown contributing to death be 28c. Date of Injuiction be 28e. Place of injuiction be 28e. Place of injuiction be 28e. Place of injuiction contribution be 28e. Place of injuiction contribution be 28e. Place of injuiction contribution contribution be 28e. Place of injuiction contribution contributio	a consequent a consequent a consequent a consequent 2 Fetal de time of deat ut not resulting a consequent a c	Folly nice of):  noe of):	DEctopic pregnand Other (specify) of Landerlying cause grant and DOA of Landerlying cause grant and Landerly Lande	26. Place ther: 4 Nurry at ork?  e time, date at y opinion, de	e of Death Cursing Home 28d.	23e. Did to 1	23d.  bacco use of the symmetry of the symmetr	Date of deli Month  contribute to lo 3 Pro 4b. Were au prior to c death? 1 Yes  Courred  death of the courred  death of the courred  death of the courred  death of the courred	ivery Day Year  othe cause of death? obably 4 Unknow intopsy findings availat completion of cause of 2 No  cify)  ciral Route Number, is stated. e to the cause(s)		

			For State	Sta	ite of M	Marylan	id / Depa	artme	nt of He <i>te of D</i>	ealth and I	Mental Hy	-	2007	34666
			Registrar  1. Decedent's Name (First, Midd)	e, Last)			Cer	liiiCa	le oi L	eaur	2. Date of D			3. Time of Death
	Physicia			Edna E	. Wat	son					Month Octob	Day xer 14	Year 2007	2:30 A M
	/Medic Examin		4a. Facility Name (If not institution					4b. City	, Town, or l	Location of Deat			County of Deat	h
			Holy Cross Nu			_			rtons		1.5. (5)	Ŋ	Montgom	ery
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2	127 F		last birthday) Yrs.	Months		Hours Min.	(Month, D	nth ey, Year)		hplace (State or Foreign untry)
	Director	1	219 22 2088 Usual Residence of Decedent			90					Jan. 8	, 191	./ New	York
	yland how		10a. State 10b. County			10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	Be-f	ctor	MD Howa	rd		Co	lumbia							1 ☐ Yes 2√2 No
	or 28	Director	10e. Street and Number		_		_	10f. Z	ip Code				en of What Co	untry?
	sath v		5860 Stevens I			Apt. nt Ever in U		Was Dec	adant of His	21045	Specify Yes or N		JSA 4. Race - Ame	rican Indian.
0000	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or items 23a or 28e-f ehow event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Mar  Wildowed 4 ☐ Divorce	nied 1 [	med Forces  ☐ Yes 2√√ Yes, Give Sar or Dates	s? ⊡No			ecify Cuban	panic Origin? (S , Mexican, Puer Specify:	to Rican, etc.)	- 1	Black, White	
3	2 hou atura cal E		15. Decede	nt's Education			16a. Dece	dent's Us	ual Occupat	tion	diag	16b. Kir	nd of Business/	Industry
ה ה	e. en 'n Medi	Completed	(Specify only higher Elementary/Secondary (0-12)		pleted) bliege (1-4o	r 5+)	life.	DO NOT	use retired)	uring most of wo	rking			
V	filed within Hygiene. other then *	Con	12				Tail	or		18. Mother's Na	- /Cinn 4 4 intell			la Cross Fox
yland		Be	17. Father's Name (First, Middle John Williams	Last)							. Smith	e, Malgeri	Suthaine)	
<u> </u>	2 should be and Mental le marked of aumatic ev	은	19a. Informant's Name/Relation	ship (Type, Pr	rint)		19b. Mailie	ng Addre	ss (Street ar	nd Number or Ri		ber, City or	Town, State, 2	Zip Code)
Z Z	s 1 and 2 should f Health and Mer item 27 ie marke other traumatic		Sandy E. Watso					-	ush R		umbia,		21045	
e,	ss 1 a		20a. Method of Disposition	2 🗆 🗆	al from Stat	20b. F	Place of Dispo cemetery, crei	sition (N	ame of other place	)	Date	20c. Los	cation - City or	Town, State
Ē	Page ment cent: If ent: If ury or		1 XBurial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (			St	. John				8/2007	fine and the second		ity, MD
Baltimor	permit. Pages 1 and 2 Department of Health s Importent: If item 27 is eny injury or other tra once.		21. Signature of Funeral Service	Licensee	odd	M0144				s of Facility Ha olumbia			ce's Far t City	mily FH, Inc , MD 21043
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complication t only one cau	s that caus	ed the dear	th. Do not ent	- 1				arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a	MET.	ASTA	TIL	21	VER	DISEA	KE			Onset and Douth
	/Medical Examiner		resulting in death)		Due to (or a	as a consec	quence of):							
	-3	er	Sequentially list conditions, if any, leading to immediate	b	Due to (or r	43 a 60(155)	quarros of).							
	cuted	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b> c. =										
Ď,	cate be executed physicien and the burial-transit	I Ex	resulting in death) Last		Due to (or a	as a consec	quence of):							
2/p0	cate b physic the b	dical		d										
o X O			IF FEMALE: 23b. Was decedent pregnant			ne of pregn		_				2	3d. Date of de	livery
ñ	death certif e attending id for use as	Physician/M	in the past 12 months?	4[	Pregnant	2 Feta at time of c		_Ectopic ] Other (	pregnancy specify)				Month	Day Year
j O	res that the designed by the a	hys	9 Unknown		_] Unknown				-117					th
ds,	law requires that the as been signed by th 2 should be detache	b	Part II. Other significant condit	ions contribut	ing to death	s but not res	sulting in the u	inderlying	cause give	n in Part I.		Tobacco u ]Yes 2[		o the cause of death?
ecord	w require s been si should t	Completed									24a. Wa		24b. Were at	utopsy findings available
r	sician: The law certificate has t irector, page 2 s	omp									per	opsy formed? 2 No	prior to death?	completion of cause of
Vital	ian: irtifica ctor. p	BeC	25. Was case referred to medic examiner?	ai						26. Place of De	ath (Check only			
о У	Physician: r this certific ral director.	မ	1 ☐ Yes 2 🛣 No	Hospit	1 🗀 іпра		ER/Outpatie			4 Kinursing	Home 5 Re			cify)
	ding P	Certification:	27. Manner of Death  1   Natural  5 □ Pend	ng	a. Date of I (Month, I	njury Day Year)	28b. Time o Injury	of M	28c. Injury Work	at ? (es 2 □ No	28d. Describe	how injur	y occurred	
Division	f or Attandi after death. Director: A	fical	3 ☐ Suicide 6 ☐ Could	not be 28	e. Place of	Injury - At h	nome, farm, st							ural Route Number,
S	s after at Direct	Certi	4  Homicide deter		building,	etc. (Speci	ity)				City or I	ow⊓, State	,	
	To the Hospital or Attanding within 24 hours after death.  To the Funeral Director; After completely filled in by the fune	edical		I Examiner: (		s of examin				e, date and plac pinion, death occ				s stated. e to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certif	er /				2	29c. License	number		29d. Dat	e signed (Mon	th, Day, Year)
			Jasveen	Yas	Car	1 2	M)		33	185615		10/19	707	
	4 EG	li.	30. Name and address of perso						4VEI	C1:35	283, A	700	7) 20 1 1 2	2015
			31. Date filed (Month, Day, Yea	AKHA		istrar's Sign	Smill	74 7	IVL	SUITE	405, 1	ma	J / VII) ~	477)
	Sta		OCT 1	6 2007	Ale	Eur.	J. 16	LOGAL	0					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER **Physician** 2007 CARROLL WEBBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F Director 215-44-9482 Dec. 12, 1946 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Director Knoxville Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 822 Knoxville Road 21758 U.S.A. Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2√ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: δ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the Maintenance US Government permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John L. Webber Mary Price ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara M. Webber / Wife 822 Knoxville Rd., Knoxville, MD 21758 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) St. Mary's Cem. 10/13/2007 Petersville, Maryland 21. Signa of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1100 N. Maple Ave., Brunswick, MD 21716 21a. Part1. Enter the r'ase, or complications that caused the death. Do not enter the mode of dying, such as a diac or respiratory arrest, shock, or heart file. List only one cause of each line. Immediate Cause (Fin \*\* disease or condition resulting in death) Physician Due to (or as a sequence of): 5-7 Days /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed inding physician and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the aid to be detached for 2 🗆 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, δ 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No MPHITYS 24a. Was an page 2 s 25. Was case referred to pledical examiner? Yes or Attending Physician: 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

State

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29c. License number

D57643

Al Fredorian

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 0 0 Clinton K. White, Sr. 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner A/isbury Peninsula Kegional Medical Nicomico Centor If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1⊠M 2□ F Director 60 July 5, Maryland 214-46-3860 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show r than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at 1 TiYes 2000 No Director Willards MD Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21874 U.S.A. 35454 East Line Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1970 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contractor Construction Co. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Iva Worth William Lloyd White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35454 East Line Road Willards, MD 21874 Cathy Rae White (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Line Cemetery 10-13-2007 Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home Delmar, DE 13 East Grove Street 23a. Part1. Enter the diseas shock, or heart failure. sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List on the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HAGEAL Physician METASTATIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown been signed by a should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No autopsy GASTRO 2 No Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

1

(Check only one)

JIMMY D

31. Date filed (Month, Pak

29b. Signature and title of certifier

Taylor

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carroll St

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

21801

29d. Date signed (Month, Day, Year)

Suite A

10,200

07-08067 Marquita Walls

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 34669 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 16, 2007 1145 hrs Medical Examiner Marquita Walls c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Landover 6702 West Forest Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Washington If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) **Funeral** Min. Aug 11 1965 Days Hours Country) Director M 2X F DC Yrs Usual Residence of Decedent 10d. Inside City Limits 10b.County Prince George's 10a. State MD 10c. City, Town or Location Landover 1 X Yes 2 No Directo 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA 20785 6702 West Forest Rd. # 104 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. 1 X Never Married 2 Married 2 X No Yes **Black** Specify: If Yes, Give Yaar Yes 2 X No specify: Widowed Divorced à 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Private permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than injury or other traumatic event, the Medics Teacher 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Geraldine Walls Willie L. Rodney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11425 Honeysucker Court Upper Marlboro, Maryland 19a. Informant's Name/Relationship (Type, Print) Geraldine Walker/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Md. National Cemetery 10-26-2007 Laurel, Maryland Donation 5 Other Specify: 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee, 7474 Landover Road Landover, Maryland 20785 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death Complications of intrauterine fetal demise Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical XUNPENDED attending physician or use as the burial x 4\frac{\partial\_{\partia Box 68760, 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Day Year Live birth past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown has been signed by the att Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 No No certificate Division of Vitai 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? Residence 6 V Other: Scene Inpatient 2 DOA Nursing Home 5 1 V Yes No ۵ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide determined (Specify) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

DIX DEND DEN NICO FINANCIA

State Registrar DHMH 17 Rev 1/2001

**OCME 2006** 

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D. Assistant Medical Examiner 1

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

OCME

October 17, 2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 34670

		For State			Cert	ificate o	f Death					Reg. N	0		3. Time of Death	
Physician		Decedent's Name (First, Mid			2	Date of De Month October	eath Day	Yea		0825 hrs						
Examin	er		ELLEG		WEBSTER						October		4c. County of	f Deat		
	48	a. Facility Name (if not institut			ımber)		4b. City, Tov	vn, or Lo	cation of	Death		ľ	Harford	Deal	"	
		Upper Chesapeake I	Medical	Center			Bel Air							1 a p:	-th-less (State or	
Funeral	5.	Social Security Number	6. Sex		7. Age (In yrs. la	st birthday)	If Under		If Under		8. Date of	Birth(M	M/DD/YYYY	Forei	rthplace (State or gn	
Director	h	43-76-8327	1	2X F	38	Υr	Months s.	Days	Hours	Min.	Dec.	4,	1968	C	ountry) N.J.	
		Isual Residence of Decedent						L								
any	_	0a. State 10b. Count	y		10c. City,	Town or Loca	ation								10d. Inside City Limits	
<b>≜</b> ,, L		Maryland Harfo	ord		Bel	Air								1 Yes 2 X No		
Aaryland 28a-f show 1 at once.	٦٥		<u> </u>				10f. Zip C	ode				10g. (	Citizen of W	zen of What Country?		
Mary dat	Director	0e. Street and Number											_			
death with the Maryland or items 23a or 28a-f sho		507 Old Stor					2101 /as Decedent	15		-0 / 0=	neifu Voc or	US.		14. Race - American Indian, Black,		
with with pe na 2.		1. Marital Status		<ol><li>Was De Armed F</li></ol>	cedent Ever in U. orces?	S. 13. W	as Decedent Yes, specify	t of Hisp Cuban,	anıc Orig Mexican,	Puerto F	Rican, etc.)	140-		e, etc.		
death r ite	Ĕ	1 Never Married 2 X	1	1 Yes	2X No	_		×					Specify:	Ţ	White	
il", o	$\sim$			f Yes, Give Ye or Dates:		_	Yes 2			· Lafe	-1 -1	116	b. Kind of B	isines	s/Industry	
ours a	ᇷ	15. Decedent's Education (S	pecify only	/ highest gra	ade completed)	16a. Deced	ent's Usual O most of worki	ccupation	on (Give F DO NOT	use retir					S, III da su y	
72 hc	Completed	Elementary/Secondary (0-1	2)	College	(1-4 or 5+)											
036 thin 72 ne. r than ledical	립			5+		Homer	naker				(E) 1 1 d d		Own Ho			
ed wi	31	17. Father's Name (First, Midd	ile, Last)											-)		
21215-0036 and be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medical Examiner	ജി	Fred James P	elle	rino					Mary	<u>Li</u>	lliar	<u>U</u>	liana	m Cto	ato Zin Code)	
21215-003 hould be filed withind Mental Hygiene, is marked other th	2	Price Jailles Pettegrino Ja. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of Street and Number														
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland thin and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f shu amaric event, the Medical Examiner must be notified at once	١,	Joshua C. Webster / Husband 507 Old Stone Place,										ir,	MD 2	<u> City</u>	or Town, State	
and and Health		0a. Method of Disposition  Burial 2 XCremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)										'	OC. LUCATION	- Oity	or rown, outo	
it of 1				Removal	HUIII State I	-	Servic	e Co	m.	10-3	30-07		Towson	1. I	Marvland	
t. Pa		Donation 5 Other  21. Signature of Funeral Services	Specify:	ee /	1 1117	1,22	. Name and	Aderess	of Facilit	у Цот	10 D					
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er	- 1	CHEVE YYYYE	00.0		Lut	1	317 Co.	rui kesk	oury	Road	i, Abi	ngd	lon, M	ary	land 21009	
	+	23a. Part I. Enter the disease	or compl	cations that	caused the death	n. Do not ente	r the mode o	f dying,	such as c	ardiac o	r respirator	y arrest	, shock, or h	eart	Approximate Interval Between Onset and	
ysician Medical	- 1	failure. List only one car	use on eac	m line.											Death	
Examiner		Immediate Cause (Final dise or condition resulting in deat			arrhythmi s a consequence											
		or condition roseiling in good	·/ L	oue to (or a	3 a consequence	21,1										
		Sequentially list conditions, if any, leading to immediate	J	Due to (or as	s a consequence	of):										
	١ <u>ۼ</u>	cause. Enter Underlying Car	od 0													
.=	Examiner	(Disease or injury that initiate events resulting in death) La		Due to (or a	s a consequence	of):										
of Vital Records, P.O. Box 68760, ing Plysician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial - transit			d													
e exe sian a	/Medical	X UNPENDED		#MENDE	PII,27,perl	ME,g873	, 11/14/	'07 T	Γ							
760, ficate be g physic	ğ	IF FEMALE:		23c. If ye	s, outcome of pre								23d. Date Month	of deli	very Day Year	
387 rrtific ling p		23b. Was decedent pregnant past 12 months?	in the		e birth egnant at time of c		Fetal death	3	Ectop	ic pregn	aricy		None		,	
ttend	ic.	1 Yes 2 No 9	Unknown			5	Other (Spe	city)				_	1			
e dea	Physician	Part II. Other significant co			known	reculting in t	he underlying	cause	aiven in F	Part 1.	23e.	Did tob	acco use co	ntribut	e to the cause of death?	
ed by letach	by P							,	•		1	Yes	2 No	3	Probably 4 🗸 Unknown	
sign	힣	Cardiac condu	ction_	system	abnomani	L <u>y</u>					24a	Was ar	n 24	. Wer	e autopsy findings available	
rds requ	ete											autops	у	prior deat	r to completion of cause of	
e law e has ge 2 s	Completed											Yes 2			Yes 2 No	
Division of Vital Records, P.O. Box 68 tall or Attending Physician: The law requires that the death certificate death.  "In Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as		25. Was case referred to me	dical					26.Plac	e of Deat	h (Check	only one)					
tal ician s certi	B	examiner?	Ī	lospital:	Inpatient 2	✓ ER/Outpa	tient 3 [	DOA	Other <sub>4</sub>	Nurs	ing Home	5 🔲 F	Residence	S C	Other:	
FVi Physi rr this	۲	1 ✓ Yes 2 No 27. Manner of Death		28a. D	ate of Injury	28b. Time		28c. Inj	ury at Wo	ork?	28d. Des	cribe h	ow injury occ	urred		
Ing ling Afte	ü	4 77	Pending	(M	onth, Day, Year)			1	Yes 2	No						
rtend death death y the	aţi	2 Accident	Investigat	ion	Place of Injury - At	hama form	ctreet factor	v office	huilding.	etc.	28f. Loca	ation (S	treet and Nu	mber	or Rural Route Number, City	
Vis or A of A of A of A of A	EI E	3 Suicide 6	Could not	De		Home, raini,	Street, lactor	, ooo				own, St				
Dital	Certification:	4 Homicide	determine	1 - 1 - 1							ad due to th	0.000164	a/e) and mar	ner as	s stated.	
Hos 24 hu Fun etely	al	29a. Certifier 1 Certifyi	ng Physic	ian: To the	best of my knowle	edge, death o	occurred at the	ie time, i ny opinio	date and : on, death	occurred	at the time	e cause , date a	and place, a	nd due	to the cause(s)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the contraction of t	Medical		_	r:On the ba and mann	er stated.	and/or mive:							29d Date	igned	(Month, Day, Year)	
	₹	29b. Signature and title of c	ertifier	3			29		nse numb	CI			October			
_		his	h	N,	mp			0.0	.M.E.	_			Colobei	20,		
		30. Name and address of p	erson who	completed	cause of death (It	em 23a)										
	1	Ling Li, MD Ass	sistant N	/ledical E	xaminer 1	11 Penn S	treet, Ball	timore	, MD 2	1201						
9	tate	31. Date filed (Month, Day,	Year)	007	2. Registrar's Sign	ature	of an									

State of Maryland / Department of Health and Mental Hygiene 0 34671 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Jane E. Zito October 0 14 2007 11:50 A M /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dove House Westminster Carroll If Under 1 Year II Under 24 Hrs.
Months Days Hours Min. 9. Birthplece (State or Foreign Country) Pennsylvania 5. Social Security Number 8. Date of Birth (Month, Day, Year) July 8,1918 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2X F 89 Director 214-78-5233 Usual Residence of Decedent 10d. Inside City Limits r 28a-f show 10a. State 10b. County 10c. City, Town or Location 1 Yes 2X No Directo Md. Ellicott City Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 3622 Underoak Drive
Marital Status 12. Was Decedent Ever in U.S.
Amed Forces? 21042 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. item 27 is marked other than "natural", or iter other traumatic event, the Medical Examination within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: White 3.☐Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 3yrs Elementary/Secondary (0-12) I Hygiene. Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Health and Mental item 27 is marked or Mary Elizabeth Stout Howard S. Strausser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3622 Underoak Drive Ellicott City, Md. 21042 Joanne Horrell/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Department of H Important: If its eny injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 10/15/2007 Catonsville, Md. Metro Crematory Inc 22. Name and ddress of Facility Harry H. Witzke's Family F.H. Inc. 21. Signav re o Funeral Service Lens 4112 Old Columbia Pike Ellicott City, Md. 21043 MOO845 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician Acuto STROKE One week /Medical resulting in death) Due to (or as a consequence of). Examiner One Localk - Vasculai Hule (grebyo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner death certificate be executed attending physician and for use as the burial-transit Jean Due to (or as a consequence of): resulting in death) Last Box 68760, Physiclan/Medlcai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I ed by the a 1 ☐ Yes 2X No The law requires that the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, pe Dementia 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Be Completed been ostes authoritis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate has page 1 Yes 2**X** No 1 Yes 2 XNo funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A М 1 ☐ Yes 2 ☐ No investigation the 1 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies · B. Hels D. 30469 October 15, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2KWAY, # 308, COLUMBIN, MO. 21045 N.B. VELLANKIND COLUMBIA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCT 1 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 23 2607 /Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHING CENTER DURNIE edical 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday, 5. Social Security Number **Funeral** Country) Months Days Hours 1 M 2 F India 02 05 220-23-9451 78 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Linthicum Anne Arundel Director MD with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pakistan 21090 603 Eairmeade Ct. Funera 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify Asian ρ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than any injury or other traumatic event. the Me Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 8th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Zanib Bibi Khahir Din 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 603 Fairmeade Ct., Linthicum, Md 21090 Zafar Ahmad-Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 10/23/07 Randallstown, Md 4 Donation 5 Other (Specify) 21 Signature of Funeral Service Licenses March Fy H West 4300 Wabash Ave, Baltimore, Md 21215 humpson Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part1 Immediate Cause (Final 110monnatoiL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner -11m Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): vision or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months?
1□Yes 2□No
9□Unknown Month Day 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 2 No 1∏ Yes Hospital or Attending Physician; 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3□ DOA 2 ☐ ER/Outpatient Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred funeral 28c. Injury at Work? After (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide within 24 hours aft To the Funeral DI completely filled in 🛮 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

MONE WASM' 31. Date filed (Month, Day, Year)

> 0 2007

29b. Signature and title of ertifier

32. Registrar's Signature

no completed cause of death (Item 23a) (Type, Print)

MEDICAL CONTER GUY BURGET

the

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19a per inf 9874 12-3-07 vt
State of Maryland / Department of Health and Mental Hygiene 1- For State Amend #18 Per FH 0872 10/30/07 JH Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Day **Physician** Angle Alston
4a. Facility Name (if not institution, give street and number) Alston OCTOBER 24 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner PALTIMORE

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. PALTIMORECITY GOOD SAMANTAN HOSPITAL 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 □ 242-58-7165 -27-1918 Director with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 Wes 2 No Baltimore Director MD10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or adical Examiner must be r U.S. Westfield Avenue 2121<sup>4</sup> 2104 death \ by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ₩idowed 4 Divorced Black Completed ithe Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If item 27 is marked other that any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Walter Silver ဂ္ 19a. Informant's Name (Relationship (Type. Print)

Daniel Alston Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 Westfield Ave Baltimore, MD 21214
ce of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 10.30.2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 22. Name and Address of Facility Voughn C. Oreene Funeral services 21. Signature of Funeral Service Licensee 4905 York Ad Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HONIC DESTRUCTIVE Kumowary /Medical Due to (or as a consequence of): Examiner KIDNET HRONIC Cause, tlainy not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician; The law requires that the death certificate be executed ANEMIA Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical HOUNIC HEART 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 4 Unknown 3 Probably NSTEM 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No VEIN THROMPOSIS-24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2/No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 1 TYes this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending investigation within 24 hours are: \_\_\_\_\_ Ye the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier TOBER Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMARIAN HOSPITAL BACTIMORE 9000 MD Registrar's Signature Year) 2007 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 25 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Bultmore Shock Troume If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 183243388 1 □ M 2 ■ F Yrs. 80 Director July 15, 1927 London, England Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City. Town or Location 10h. County 10d. Inside City Limits items 23a or 28a-f show iner must be notified at 1. Yes 2 No Maryland Director Baltimore Parkton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21120 17701 Funeral Masemore Road USA 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give ō, 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: White 3 ⅓ Widowed 4 ☐ Divorced Year or Dates: "naturel", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ∡ then > Elementary/Secondary (0-12) College (1-4or 5+) 12 own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Peirce Greebe Edith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monkton, MD ZIIII Valerie Schultz/ Daughter P.O. Box 579 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If Ite
eny Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State October 25,2007 Hanover, MD Anatomy Gifts Registry 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Drive Suite P. Hanover MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 9 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER to (or as a consequence of). Examiner death certificate be executed Pue to (or as a consequence of): attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 5 Other (specify) ed by the a detached f ate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed? Yes 21 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2☐No ↑ Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1105 1 ☐ Yes 2 No 2 Accident 10/24/2007 rall To the Hospital or Attendenthin 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P21765 address & person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

3 0

2007

14ANOWEL

Grec

32. Registrar's Signature

31. Date filed (Month, Day, State Registrar

and address of pers

Year

EX no 32. Registrar's Signature

ho completed cause of death (Item 23a) (Type, Print)

DEFENSE HIGHWAY ANNAPOLO MDH401

07-08364 Ian Baggett Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

n Baggett		For State	te of Maryland		rtment of tificate of			Menta	Hygie	ne Reg.	No. 20(	7	346	76
Physician	1	egistrar . Decedent's Name (First, Middle,							Mo	te of Death	av Year	3. Ti	me of Death	$\neg$
Medical Examine		a. Facility Name (if not institution,	Ian A.	Bagg	ett, J	b. City. To	wn, or Lo	ocation of D		tober 27,	4c. County of De			$\dashv$
		Northwest Hospital Cen		,		Randa	llstown	1			Baltimore Co			
Funeral		Social Security Number 6	. Sex 7. A	Age (In yrs. la	ast birthday)	If Under	_	If Under 2	24Hrs. 8. D Min.	ate of Birth	MM/DD/YYYY) 9.1 For	eian		
Director	⊢		1 X M 2 F	24	Yrs Yrs		Days	110010	0	CT 18	, 1983	Country	Maryland	1
n y	-	Usual Residence of Decedent  10a. State  10b. County		10c. City,	Town or Locati	ion	_						Inside City Lim	1
Maryland 28a-f show any d at once.	۱	MD Car	roll			Sy	kesv	ille					Yes 2 X	No
Maryla 28a-f d at or	Director	10e. Street and Number				10f. Zip (		1		10g	. Citizen of What C	ountry?		
with the Maryland ns 23a or 28a-f sho		2816 Kaywood	Place	ent Ever in II	S 13 Wa	s Deceder		1784	? ( Specify '	Yes or No-	USA 14. Race - An	nerican I	ndian, Black,	$\dashv$
eath wi		1 X Never Married 2 Mar	aind Armed Force		If Y	es, specify	Cuban,	Mexican, F	Puerto Rican	, etc.)	White, etc			
after d			ced If Yes, Give Year			Yes 2					Specify:	Whit		_
hours natur	Completed by	15. Decedent's Education (Specific Elementary/Secondary (0-12)	fy only highest grade of College (1-4)		16a. Deceder during m	nt's Usual C nost of work				one [1	16b. Kind of Busine	3S/Indus	try	
136 thin 72 te. than '	e l l l l	Liemental y/Secondary (0-12)	1		Automo	otive	Tec	hnici	an		Automotiv	e Re	epairs	
11215-0036 Id be filed within 72 hours a Menial Hygiene narked other than "natural event, the Medical Examina		17. Father's Name (First, Middle, L			Sr.		18				aiden Surname)	~ .	3 40	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	9 Be	Ian A  19a. Informant's Name/Relationshi	ah Route Numb	L . er, City or Town, Si	Sei tate, Zip	Code)								
nore, MD 2 ages I and 2 shoul ent of Health and M ett. If item 27 is in	_	Ian A. Baggett,		her	1									34
re, l s 1 and f Healt If item er tran		20a. Method of Disposition  1 Burial 2 X Cremation		State	crematory or ot	ther place)								
Page ment o		4 Donation 5 Other Spe	ecify:	Met	ro Cre	mator	y, I	nc. 1	0/29/	07 ]	Baltin Society o	ore	MD_	
Baltimo permit. Page Department or Important: injury or out	I	21. Signature of Funeral Service L	icensee George	MacNa	abb $\begin{vmatrix} 22.1 \\ 2 \end{vmatrix}$	name and QQ Fr	eder	orracility	Crema Coad	tion : Relti	Society o more, MD	1 MI 211	), Inc.	Į
Physician	+	23a. Part I. Enter the disease, or o	complications that caus	ed the death	. Do not enter	the mode o	of dying, s	such as car	rdiac or resp	piratory arres	st, shock, or heart	A	pproximate Inteletween Onset	
/Medical xaminer	ı	failure. List only one cause of Immediate Cause (Final disease	a. Multiple Injuri									-	Death	
Xaiiiiioi		or condition resulting in death)	Due to (or as a co	nsequence o	of):									
	直	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	nsequence o	of):									
	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence o	of):		_							
ecuted and - transi	dical E		d	<del></del>			<u> </u>				<u> </u>	+		$\dashv$
o, o, e be ex ysician burial		UNPENDED	AMENDED	come of pred	nancy						23d. Date of del	ivery		-i
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	, cive bird	1	2 F	etal death	3	Ectopic	pregnancy		Month	Day	Year	
ox 6 eath ce ath ce for use	sici	1 Yes 2 No 9 Unkr		t at time of de	eath 5 C	ther (Spe	cify)							1
Division of Vital Records, P.O. Bupital or Attending Physician: The law requires that the decurs after death.  eral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached it.	Phy	Part II. Other significant condition	ons contributing to d	eath but not i	resulting in the	underlying	cause g	iven in Par	t I.		pacco use contribut			
S, P.	od by					<del> </del>			— ļ		2 No 3		y 4 Unkno	
ords aw requas beer	Bet									24a. Was a autops	sy prior	r to com	pletion of cause	
Rec The la ficate h	Completed						00 51	of Dooth /	Check only	1 <b>✓</b> Yes 2		Yes	2 N	)
'ital sician:	a	25. Was case referred to medical examiner?	Hospital: 1 Inc	atient 2	ER/Outpatier			0.11	Nursing Ho		Residence 6 0	Other:		_
of V ig Phy filter th	2	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of (Month, D	Injury av.Year)	28b. Time of	Injury		y at Work?	IMot		ow injury occurred involved in col	lision		
ion ttendii death.	aţio	1 Natural 5 Pendi 2 ✓ Accident Inves	tigation		1352 hrs			res 2 🗸	No				Pauta Number	City
Divisior of or Attend s after death	Certification:	deter	not be		nome, farm, str ad / Highwa		, office b	uilding, etc		or Town, St	street and Number of tate) at Old Liberty Roa			City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Cortifying Ph	veician: To the hest (	of my knowled	dae, death occ	urred at the	e time, da	ate and pla	ce, and due	to the cause	e(s) and manner as	stated.		
To the Hos within 24 h To the Fun	Medical	one) 2 Medical Exam	miner:On the basis of and manner sta	examination.	and/or investig	ation, in m	y opinion	, death occ	curred at the	time, date	and place, and due	to the ca		
	ž	29b. Signature and title of certifie	11/	-		29	c. Licens O.C.I	e number M F			29d. Date signed October 28, 2		Day, rear)	
		30. Name and address of person	Who completed cause	of death (Ite	m 23a)		0.0.1							
10 1		//	uty Chief Medica			enn Stre	et, Bal	timore, N	MD 2120	1				
	ate	31. Date filed (Month, Day, Year)		istrar's Signa	ture	Sall B								
Regist	rar	00,00	LUUI MERCE	The Such s	ASS	Charles Carps								

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 34677

			or State			C	ertificat	e of	Death					Reg. No.		- 10	T:f D-	-41-
Physic	ian/		gistrar Decedent's Name (First, M	ddle,Last)								- 1	Date of De Month	Dav	Yea		Time of De 1239 hrs	
Exam			Christopher D Burden								October 25, 2007							
		4a	. Facility Name (if not instit					4	b. City, Town,		ion of D	eath		40				
			University Hospital		Baltimore						N/A rs.   8. Date of Birth(MM/DD/YYYY)   9. Birthplace (State or					0.5		
Funera		5.	Social Security Number	6. Sex		7. Age (In yrs	s. last birthd	ay)	If Under 1 \				8. Date of B	Birth(MM	/DD/YYYY	II-oreian		OI
Directo		1		1 3	M 2 F		23	Yrs.	Months [	ays H	lours	Min.	APR 4	198	34	Cour	ntry) MD	
		_	217-06-9153	<u></u> _														
ž.	1	_	sual Residence of Deceder  la. State 10b. Cou			10c. C	ity, Town or	Location	on								10d. Inside C	
# ar		1		altimore						1 X Yes 2					2 No			
land f she	غ ا	āL	MD	<u>_</u>	10f. Zip Code						10g. Citizen of What Country?							
death with the Maryland or items 23a or 28a-f show any must he notified at once.	Director	김   10	e. Street and Number										TTO	SA				
the sa or	ة		3703 Tenth Street					21225 S. 13. Was Decedent of Hispanic Origin? (S					oify Voc of	No-			an Indian, Bl	ack,
with ns 2.	Lengan	1	11. Marital Status  12. Was Decedent Every Armed Forces?				n U.S.	13. Wa If Y	as Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto R				Rican, etc.)	140	White, etc.			
death r ite		<u> </u>	X Never Married 2	Married	1 Yes	2 X N	0		Yes 2 X No specify:						Specify: Black			
15-0036 filed within 72 hours after death with the Maryland l Hygiene. de other than "matural", or items 23a or 28a-f she		٠ اح	Widowed 4		If Yes, Give Ye or Dates:			1					ork dono	166		DIG		
ours a			15. Decedent's Education	duri						edent's Usual Occupation (Give kind of work doning most of working life. DO NOT use retired)					b. Kind of Business/Industry			
72 hc n "ns		ompieted 1	Elementary/Secondary (0-12) College (1-4 or 5+)										Fast Food					
thin than than		림	10	- 1			Ki	tch	en Wor	ker			(First, Midd	la Maide			1	
ed wi		3 1	7. Father's Name (First, Mi	ddle, Last)											_			
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", 'Andrea of the Medical Framines.		8		rden						نط	aVeı	rne	H.		ohnso		Zin Code)	
D 2121 should be fil and Mental H	2	0 1	9a. Informant's Name/Rela						g Address (									
MD d 2 sho lth and n 27 is	et .		LaVerne H. J	ohnso	n - mc	other			Magne			t, 1		np, 1	nary1	and A	Town, State	
e, M 1 and 2 Health item 2		2	0a. Method of Disposition				Ob. Place of cremato	f Dispos	sition (Name o	of cemete	ery,		Date	20	c. Localion	i - City of	10mi, Otato	
more Pages 1 nent of 1 ant: If		1	1 Burial 2 X Cren			from State				. In	c.	10/3	30/200	07   1	Balti	more	, MD_	
t. Pa trmen	ě		4 Donation 5 Other Specify:  Metro Crematory, Inc. 10/3										99,000					
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and N		- 1	21. Signature of Funeral Service Steven H. Williams  22. Name and Address of Facility Cremation Society 299 Frederick Road												nore.	MD	21228	
		-+;	23a. Part I. Enter the disease	se, or comp	lications that	caused the d	eath. Do no	t enter	the mode of d	ying, suc	ch as ca	rdiac o	respirator	arrest,	shock, or h	eart		ate Interval Onset and
ysicia /Medic		ľ	failure. List only one of	ause on ea	ach line.													eath
Examine			Immediate Cause (Final disease a. Gunshot Wounds (2) of the Head and Neck															
			or condition resulting in death)  Due to (or as a consequence of):															
		<u>.</u>	Sequentially list conditions if any, leading to immediate	entially list conditions, Leading to immediate  Due to (or as a consequence of):														
		틘	cause. Enter Underlying Cause															
	. <u></u>	Examiner	events resulting in death) Last Due to (or as a consequence of):															
760, icate be executed physician and	trans																	
e exe	rial-	/Medical	UNPENDED	L	AMENDE	D									02d Deta	of dolive		
'60, cate b	the bu	₽Ī	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregn							23d. Date of delivery  Month Day Year								
687 ertific	e as t	ian	past 12 months?	tedent pregnant in the nonths?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)									arroy					
Box 687 death certific	for use as	Sic	1 Yes 2 No 9	Unknow	_   "	known		- L	other (Specif	" —				-				
. B. he de	hed f	Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death?						
P.O.	detach		r are in Salas Significants Salas Sa									1 Yes 2 No 3 Probably 4 Unknown						
S, F uires n sign	should be d	당												Was an	24	b. Were a	utopsy findir	ngs available
v req	shou	흥												autopsy performe	ed?	death?		
ecc he lav te ha	age 2	Completed by												Yes 2		1 🗸	Yes 2	No
- 7. II. II. III.	or, p	Č	25. Was case referred to r	nedical					26	_			only one)					
Division of Vital Records, tal or Attending Physician: The law requing an are required.	director, page	o Be	examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other:															
Sf V ; Phy ter th	eral (	-	27. Manner of Death		28a. D	ate of Injury			of Injury 28	c. Injury			28d. Des Subject	cribe how	w injury oc hot	curred		
ding	e fun	5	1 Natural 5	Pending	Oct 2	onth Day Year) 24, 2007	233	35 hrs		1 Yes	s 2 🗸	No	1					
Sio Atten deat	by th	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.									28f. Location (Street and Number or Rural Route Number, City						
Join Pier	i p	틛	3 Suicide 6	Suicide 6 Could not be determined 1 (Specify) 1 acal Street										or Town, State) East Patapsco Avenue, Brooklyn, Md.				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Division: After this certificate has been signed by the attending physician and	completely filled in by the funeral		4 Homicide  29a. Certifier 1 Certifi		(-/			eath on	curred at the	ime, date	e and pl	lace, ar	nd due to th	e cause(	s) and mai	nner as si	ated.	
n 24	Jetel	Medical											at the time	e time, date and place, and due to the cause(s)				
To the	comp	edi			and mann	er stated.				License					29d. Date	signed (I	nonth, Day, Y	'ear)
		Σ	29b. Signature and title o	cermer						O.C.M					Octobe	r 26, 20	07	
1			Yamete HI	Hell	, mD					5.0.11								
5	ļ		30. Name and add as of			cause of deat	h (Item 23a	)	111 Penn	Ctroot	Balti-	more	MD 212	01				
1			Pamela E. Sout	0.0		ant Medica		er	iii Penn	Sueet,	Daitil	noie,	1410 612					
	s	tate	31. Date filed (Month, Da	y, Year)		2. Registrar's	Signature	-	1 20 -					OCME				
ъ.		trar	100	3.0	2007	A Wallage	4 5%	20	THAT I					MAIL				

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

ORIGINAL

555 W.

Towsanteur Blud/Balto MD 21204

Name and address of person who completed cause of death (Item 23a) (Type, Print)

aulkner MO/

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician h. Nellie. Burns 04 2007 October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMURE SAINT AGNES HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 578-40-535c 3 . 31 . 1928 Michigan Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County rai", or items 23a or 28a-f show Examiner must be notified at 1 Pres 2 No MD Funeral Director Baltimore 10e. Street and Number 10g. Citizen of What Country? 21223 310 South Norris Street U.S.A Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ NO Specify Completed by 3 ₩idowed 4 Divorced white "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) أتتنو Mknown JNKnown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f unknown unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: If Item 27 is ready injury or other 310 S. Norris St. Baltimore, MD 21223 Kathleen Howlett/care taker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State nown whown Battimore, MD
22. Name and Address of Facility Compassion Fureral Services 4 Donation 5 Other (Specify) unknown unknown 21. Signature of Funeral Service Licensee MD0944 119-121 South Stricker Street Baltimore, MD 21223 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he it lailure. List only ne cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** acidosis Metabolic 2 how /Medical Due to (or as a consequence of): Examiner Hypoxia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 10 hours Hypo Kalemia Due to (or as a consequence of): 3 days Pneymonia Physician/Medical Aspiration IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Vear Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division or Vital Records, Alcoholism 1 Yes 2 No 3 Probably 4 Onknown Hyper tension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No e Hospital or Attending Phys 24 hours after death.
e Funeral Director; After this letely filled in by the f. neral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the desired forms and the desired forms Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier I avia M MD 19514 October, 04,2001

DHMH 17 Rev 1/2001

Registrar

グロして

SURNS

900 Caton Ave

21229

Baltimore

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

MAHMOOD

TARIQ

31. Date filed (Month, Day, Year)

OCT 3 0 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** BOOKER OCTOSER 25 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE UNIVERSITY OF MARNLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/8/1931 5. Social Security Number Age (In yrs, last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗓 F Hours Country) \Virginia 223-38-7362 75 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10h. County 10d. Inside City Limits MD Anne Arundel Hanover 1 ☐ Yes 2X No Director 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 7407 Hawkins Drive 21076 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify white ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Metal Company Order Writer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Wickham Beatrice Alice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Richard W. Booker/spouse 7407 Hawkins Dr. Hanover MD 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10g0/<sub>2007</sub> Sherwood Memorial Park Salem, Virginia 22. Name and Address of Facility Singleton Funeral & Cremation 21. Si nature | Fune Il Servier Fi M01364 1 2nd Ave Sw Glen Burnie MD 21061 Srvc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASPIRATION PNEUMONIA DAYS /Medical Due to (or as a consequence of) MONTHS PLEURAL Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) MITRAL VALVE Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 | Yes 2 | No 3 | Probably 4 Unknown FIBRILLATION Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ▼No autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Examiner Ö ۵ Records, or Vital Division To the Hospital or Attending

28a-f show

"natural", or items 23a or 28a-f shov dical Examiner must be notified at

event, the Medical

is marked other than

permit. Pages 1 and 2: Department of Health all Important: If Item 27 is

injury

burial-transi

the SB attending p for use as

signed by the a

has e 2

certificate

this funeral

After

within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

page

and

physician

and 2 should be filed within 72 hours after death with ealth and Mental Hygiene.

Baltimore, Maryland 21215-0036

6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAULD LIGHT

UNIVERSITY OF MARYLAND

31. Date filed (Month, Day, Year) 3 0 2007 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCTOBER **Physician** 6:20 PM 24 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bd Medical howe NA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea) 4-9-1944 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 218-44-7224 63 Md. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County od 2 should be filed within 72 hours after death with the Marylan tith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1¶ Yes 2 □ No Director Baltimore Md. NA 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21206 USA 4409 Moravia Rd. Apt. 11 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Director Parks & Recreation 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ... 1 and 2 should be of Health and M Bond Lottie Bazemore W. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4409 Moravia Rd. Apt. 11, Baltimore, Md. Rozella R. Bond Wife permit. Pages 1 and Department of Healt Important: If item 2: any injury or other 3 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 10-29-07 Arbutus , Md. Arbutus Mem. Pk. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F. Η. East 21202 1101 E. North Ave., Baltimotr, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final year **Physician** large cell disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, many, reading to mini solutions cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) certificate be executed burial-transi Exami and resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy 1 | Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Impatient Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred I or Attending F after death. 1. Natural 5 Pending Injury thin 24 hours arter co. 4 the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

To the I within 2 Registrar

DHMH 17 Rev 1/2001

State

29b. Signature, and title of certifier

31. Date filed (Month, Day,

30 Name

Market &

301

ST. Paul ST. Ralfineon, MO

and manner stated.

MD

32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

7 HRI

3 0 2007

		4	For State Registrar	State of Mar		artment of F rtificate of				01.600
			Registrar  1. Decedent's Name (First, Middle, Last)			i tilicate of i	Dealii	2. Date of Death	g. No. 2 0 0 7	3. Time of Death
*)	Physicia	an	Robert	J.	Blackwel	1		Month	Day Year 2007	6;03p M
	/Medic Examin	_	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	r Location of Death		4c. County of Deatl	
	LAGIIIII	٠.	Gilchrist Hospic	e		Towso	on		Baltin	nore
	Funeral		5. Social Security Number 6. Sex	7. Age (	In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		nplace (State or Foreign untry)
e Tab	Director		219-40-4001	JW ZUF	63 Yrs.			10-22-1	1944	Md.
	and ww		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or L	ocation				10d. Inside City Limits
	Maryl f sho	Į0	Md. NA		Bal	timore				1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	th wit 23a o ist be		2642 E. Hoffman S	Street		212	1.3		USA	
	ems er mu	Funeral		12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
36	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 2√2 No	Specify:		Specify: Bla	ack
Ö	hour tural	q pe	15. Decedent's Edu	Year or Dates:	16a, Dece	edent's Usual Occur	oation	1	16b. Kind of Business/	
7	in 72 n "na" fedic	Completed	(Specify only highest grade	e completed)  College (1-4or 5+)	(Give	e kind of work done DO NOT use retire	during most of wor			,
212	with glene. r thai	E O	10th grade	NA	l l	ong Shore	eman		STA	
פַ	be filed ntal Hygik od other event, th	Be C	17. Father's Name (First, Middle, Last)			2	18. Mother's Nan	ne (First, Middle, M		
Maryland 21215-0036	should b and Ment marked umatic e	2	Detroy	Bla	ckwell		Ruth		Brooks	
Jar			19a. Informant's Name/Relationship (Ty	•	1	•			City or Town, State, 2 imore, Md.	Zip Code) 21213
G,	permit. Pages 1 and 2 Department of Health s Important; If Item 27 is any Injury or other tra	1	Deborah M. Blackw	vell Wife					20c. Location - City or	
altimore,	nt of int of it.		1 Burial 2 ☐ Cremation 3 ☐ F			osition (Name of ematory or other pla	1		Laurel, Md	
틒	artme artme ortant Injury	1	4 Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens		the second secon	. Mem. Pk	1	29-07   1 March F.1		•
Ba	permii Depar Impor any Ir		& lady	Wa	Len	1101 E.	North Ave	e., Balti	more, Md.	21202
e			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	lications that caused t	he death. Do not er	nter the mode of dyi	ng, such as cardia	c or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	De la	tra					Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of):				-	
ŀ	Examiner		Sequentially list conditions,	b						
8	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
6	xecut and al-tran	Examiner		c Due to (or as a	consequence of):					
8760,	ficate be executed physician and is the burial-transit	dical E		d						
289	ificate g phy as the	edic		u				W1 - 030		
Вох	The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	Completed by Physician/Me	23b. was decedent pregnant	23c. If yes, outcome p 1 □Live birth 2		□Ectopic pregnanc	°v		23d. Date of de	*
<u>.</u>	ed for	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at t		Other (specify)			Month	Day Year
P.O.	at the	Phy	9 Unknown		not reculting in the	underlying course gi	von in Part I	23a Did toh	pacco use contribute to	the cause of death?
ŝ	aw requires that s been signed t should be deta	by	Part II. Other significant conditions co	nthbuting to death but	not resulting in the	undenying cause gi	veii iii rait i.	1 □ Ye	2.5	robably 4 Unknown
Ö	requi	eted	Spoke							
3ec	has the general	킅						24a. Was ai autops pertorr	sy prior to	utopsy findings available completion of cause of
a	sician: The law certificate has t irector, page 2 s		OF Man area referred to medical				00 0110-		2XNo 1□Yes	2 □ No
Division or Vital Records,	Physician: The is rithis certificate had ral director, page 2	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 ☐ ER/Outpati	ent 3 DOA Ot	her:	ath (Check only on Home 5 Reside		reify Hospice
0	g Phy er this eral d	7: To	27. Manner of Death	28a. Date of Injury	/ 28b. Time	of 28c. Inju			ow injury occurred	icity) • Di • OC
ion	Attending r death. ector: After by the fune	atio	1 Natural 5 ☐ Pending investigation	(Month, Day	Year) Injury		Yes 2 No			
vis	Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injur	y - At home, farm, s	street, factory, office		28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
Ö	Ital or is after ral Dir led in b	Cer								
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		(Check only 2 Medical Exam	iner: On the basis of	examination and/or				ause(s) and manner a late and place, and du	
	thin 2 the o the	Medical	one) 29b. Signature and title of certifier	and manner stat		29c. Licen	se number	2	9d. Date signed (Mon	th, Day, Year)
	Net No		> alruh	m		D5	18303	10	Kroser S	42007
7			30. Name and address of person who d	completed cause of de	ath (Item 23a) (Type	e, Print)			19d. Date signed (Mon KTOBER S 2124	- /
	A'		ARRON J. WAR	ues mo	6701 NO	harks S	t Tovso	no a	znoy	
100	-	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature					

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3468 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Month 000 **Physician** 10:15 12007 /Medical 4b\_City, Town, or Location of Death 4c. County of Death Facility Name (If ript institution, give street and number) Examiner 17; Da WALL MORE N/A 6 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min 1 ☐ M 2 🖵 F 212-50-7175 63 08/24/1944 Director MDUsual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1 ☐Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2212 SHEFFLIN COURT 21209 <u>U.S.A</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CUSTOMER SERVICE REP. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WALLER MINNA ROSENTHAL ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2212 SHEFFLIN COURT - BALTIMORE, MD 21209 NORMAN N. BLOOM / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL 10/28/2007 | RANDALLSTOWN, MD 22. Name an of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS.. INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21268 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** pronory disease or condition resulting in death) /Medical Due to (or as a cons --- nce of): Examiner tension Der Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (pr as a consequence of). Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 ☐ No Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 √Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 ☑ Natural 5 Pending investigation after death.

Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d., Date signed (Month, Day, Year)

Registrar

State

10.VA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year) 0 2007 0,00

Registrar's Signature

1 Supple 1

07-08292 Michael Abrahar		A	delible Ink. iment of He ificate of De	ealth and Mental Hy	s Are Legi /giene	200	7 3468
Physicia Medical Exami	ın/	Decedent's Name (First, Middle,Last)			2. Date of Death Month I October 25,		3. Time of Death 0155 hrs
Wedical Exami	ilei	MICHAEL ABRAHAM  4a. Facility Name (if not institution, give street and number)		ALL ity, Town, or Location of Death	October 25,	4c. County of Dea	
`. 		1205 Baker Place Apt. 43  5. Social Security Number   6. Sex   7. Age (In yrs. lat		ederick Under 1 Year I If Under 24Hrs	8 Date of Birth	Frederick (MM/DD/YYYY) 9. B	Birthplace (State or
Funeral Director		217-06-6964 1XM 2F 23		onths Days Hours Min.	05/12/	Fore	
'n		Usual Residence of Decedent	Town or Location	····			10d. Inside City Limits
nd how any ee.	L	10a. State 10b. County 10c. City, 7 HOWARD	COLUMBIA				1 Yes 2 No
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number		. Zip Code	10g	g. Citizen of What Co	untry?
ith the ] 23a or notifie		5652 BLITHEAIRE GARTH  11. Marital Status  12. Was Decedent Ever in U.S.		1045 cedent of Hispanic Origin? (Sp	ecify Ves or No-	U.S.A.	erican Indian, Black,
death w r items	Funeral	1 Never Married 2 Married Armed Forces?		pecify Cuban, Mexican, Puerto		White, etc.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
s after in ral", o	þ	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)		s 2 X No specify:	york done	Specify:	WHITE
72 hour n "nate	eted	Elementary/Secondary (0-12) College (1-4 or 5+)		f working life. DO NOT use reti			<b>.</b>
5-0036 lled within 7 Hygiene. I other than	ompleted	2 17. Father's Name (First, Middle, Last)	COUNSEL	OR 18.Mother's Name	(First Middle Ma	HEALTH C	ARE
21215- vuld be filed Mental Hyg marked oth	Be C	ARON	BRALI		(Thot, Middle, Mi	arden damane,	EDELL
D 21 should and Mer 7 is man	၉	19a. Informant's Name/Relationship (Type, Print )		dress (Street and Number or F			
e, MD 1 and 2 sho Health and item 27 is				ITHEAIRE GARTH (Name of cemetery,	Date Date	20c. Location - City	
Baltimore, permit. Pages I an Department of Hea Important: If ite		Y Dunal 2 Cremation 3 Removal from State	H EL		8/2007	PARAMUS.	NJ
Baltimore, MD 21215-0036  Departine Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiewie Important of Health and Mental Hygiewie Important: If view 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		and Address of Facility		NSON & BR	
Physician		23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line.		OO REISTERSTOW ode of dying, such as cardiac of			Approximate Interval Between Onset and
/Medical xaminer	1	Immediate Cause (Final disease a Gunshot Wound of Che					Death
·,		or condition resulting in death)  Due to (or as a consequence of)  Sequentially list conditions,  b.	):				
	miner	if any, leading to immediate Due to (or as a consequence of	):				
ed nsit	Exan	events resulting in death) Last  Due to (or as a consequence of	):				
Box 68760, e death certificate be executed the attending physician and red for use as the burial - trans	lical	d. UNPENDED AMENDED		<del></del>	-		
760, ficate bug physic	/Mec	IF FEMALE: 23c. If yes, outcome of pregn 23b. Was decedent pregnant in the		eath 3 Ectopic pregna	anov	23d. Date of deliv	rery Day Year
Box 68760 e death certificate be the attending physical of for use as the bu	sician/Medical	past 12 months?  4 Pregnant at time of dea	2 Fetal de ath 5 Other	(Specify)	incy	I I I I I I I I I I I I I I I I I I I	Day
D. Bc the dea by the a	Phys	Part II. Other significant conditions contributing to death but not re	sulting in the under	rlying cause given in Part I.	23e. Did tok	pacco use contribute	to the cause of death?
, P.O. res that the signed by be detac	þ				1 Yes	2 No 3 P	robably 4 Unknown
ords, w requir as been s	Completed				24a. Was a autops	y prior t	autopsy findings available to completion of cause of
Rec The la ficate h	Com			Of Place of Death (Check	perform		
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the and the death.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	o Be	25. Was case referred to medical examiner?  1. ✓ Yes 2 No  Hospital: 1 Inpatient 2	ER/Outpatient 3	26.Place of Death (Check  Other  DOA  Other  Nursin		Residence 6 🗸 Ot	her: Scene
1 of Jing Ph. After t	-	27. Manner of Death 28a. Date of Injury (Month Day Year)	28b. Time of Injury 0147 hrs		28d. Describe h	ow injury occurred	
isior Attend er death rector: by the	ertification:	2 Accident Investigation 28e. Place of Injury - At ho		1 Yes 2 No	28f. Location (S	treet and Number or	Rural Route Number, City
Division  Bospital or Attend 24 hours after death. Funeral Director:	Certif	4 Homicide determined (Specify) Apartment			or Town, St		
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death.  To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledgene one)  Medical Examiner: On the basis of examination are					
To t with To t	Medical	29b Signature and title of certifier		29c. License number		29d. Date signed (/	
		D. () (200		O.C.M.E.		October 25, 20	)07

10

State 31. Date filed (Month, Day, Year)
Registrar

Patricia Aronica-Pollak MD.

Assistant Medical Examiner

32. Fegistrar's Signature

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Physici /Media Examir

**Funeral** 

1 - For State Registrar

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran

1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year  3. Time of De										
an	LILLIAN		BRA	M	OCTOBER		3:30 A <sup>M</sup>			
al er	4a. Facility Name (If not institution, give street and number)  LEVINDALE HEBREW HOME		4b. City, Town, C	or Location of Death	1	4c. County of De				
	5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthda)	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. B	Birthplace (State or Foreign			
	373-16-4536	89 Yrs.	Months Days	Hours Min.	12/08/19	17	Country) MI			
	Usual Residence of Decedent	L					Track to an in the			
_	10a. State 10b. County	10c. City, Town or I	Location				10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
cto	MD N/A	BALTIM	IORE			Ι Χ				
E E	10e. Street and Number	-	10f. Zip Code		10	g. Citizen of What	Country?			
ra	3808 W. STRATHMORE AVENUE		21215			U.S.A.				
n n	11. Marital Status  12. Was Decedent Armed Forces?	Ever in U.S.	B. Was Decedent of I If Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.				
by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, 2 🐧 1 ☐ Yes, Give Year or Dates:	10	1 ☐ Yes 2X No	Specify:		Specify:	WHITE			
Be Completed by Funeral Director	15. Decedent's Education	16a. Dec	edent's Usual Occu	pation	// 1	I 16b. Kind of Busines	ss/Industry			
ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5	life	ve kind of work done . DO NOT use retire	during most of wor d)	king					
ĕ	12	TEAC	HER	,		EDUCATI	ON			
Be (	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle, M	faiden Surname)				
2	ELIEZER	TR	ON	REBECC/	P	MIT	NER			
3	19a. Informant's Name/Relationship (Type. Print)	- 1	iling Address (Street			•				
	REBECCA FELDBAUM/DAUGHTER		W. STRAT	HMORE AVI						
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cr	position (Name of rematory or other pla ISRAEL C(	NG 10/2	8/2007	20c. Location - City BALTIMORI				
	4 Donation 5 Other (Specify)					DALITIUN				
	21. Signature of Mineral Service Licensee		22. Name and Addre		OL LEVINS	OTKECATILI	E. MD 21208			
	23a. Part1. Enter the disease, or complications that caused	I the death. Do not a					Approximate			
	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final									
	disease or condition a.	PSIS					2 0AYJ			
	CACOA	a consequence of):	UBITUS	NICER			2 May mer			
e e		a nonsequence of):	0/21/03	Ofcek	•		[ 1-000 114 ]			
min	cause. Enter Underlying Cause (Disease or injury that initiated events									
Еха		a consequence of):								
ical	d									
cian/Medical Examiner	IF FEMALE:					1				
an/l	23h Mas decedent pregnant 23c. If yes, outcome	2 Fetal death 3	B □Ectopic pregnanc			23d. Date of Month	delivery Day Year			
sici	1 Yes 2 No 4 Pregnant a	t time of death	Other (specify)			WOTH	Day real			
Completed by Physic	9 Unknown  Part II. Other significant conditions contributing to death b	ut not reculting in the	underlying cause gi	von in Part I	23e Did toh	acco use contribute	e to the cause of death?			
by	Tartin Striet significant conditions continuing to death b	at not resulting in the	underlying cause gr	ven in r are i.	1 □ Ye	<b>.</b>	Probably 4 ☐Unknown			
etec										
mpl					24a. Was ar autops perforn	y prior	autopsy findings available to completion of cause of			
ပိ	07.11				1□ Yes 2	No 1 □ Y				
Be c	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatie	ent 2 ☐ ER/Outpati	ient 3 DOA Ott		ath (Check only one					
٠ <u>.</u>	27. Manner of Death 28a. Date of Inju	ry 28b. Time	of 28c. Inju			nce 6 Other (S	peciry)			
tior	1 Natural 5 Pending (Month, Da 2 Accident investigation	y Year) Injury		ork? ]Yes 2∐No						
ifica	3 Suicide 6 Could not be determined 28e. Place of inj	ury - At home, farm,	street, factory, office		28f. Location (Str City or Town		Rural Route Number,			
Sert	4 Holling en	c. (Specify)			City of Town	, State)				
cal (	29a. Certifier 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of									
Medical Certification:	one) and manner st									
-	29b. Signature and title of certifler			se number	25	9d. Date signed (Mo	Omin, Day, Year)			
	the the tho			5039		10/28/	0.1			
	30. Name and Address of person who completed cause of d	eath (Item 23a) (Typ	e, Print)	RIDI	714RE	MD 21	209			
ite		ar's Signature	A YOR	(DITC	-(1, 4-6	- 12 -1				
ar	OCT 3 0 2007 Description	o Brill	CARL							

State

Registrar

OCT 3 0 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** HARRY BELKOWITZ 10 1007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 12ANDALL STOWN NORTHWEST HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days 91 215-18-0785 Director 09/06/1916 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 2 POMONA WEST, APT. 21208 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any Injury or other traumatic event. the Μα Elementary/Secondary (0-12) College (1-4or 5+) OWNER GAS STATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM BELKOWITZ IDA STOLLER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LIBBY SMULOVITZ / SISTER 2 POMONA WEST, APT. #7, BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State RODFE ZEDEK CONG. 10/28/2007 BALTIMORE, MD 4 Donation 5 Dother (Specify) 21. Signatur of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. HO 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EPSIC **Physician** /Medical Due to (or as a consequence of): **Examiner** MEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 🖔 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death . Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760.

burial-tran

the

use

Po

ed by the a detached i

cate has been signated bage 2 should b

funeral director,

certificate has

this

After

iours after death.

neral Director: A
filled in by the for

attending physician

the Maryland

death v

within 72 hours after

Saltimore, Maryland 21215-0036

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

requires that the death certificate be executed Division or Vital Records, Hospital or Attending

24 hours a To the within 2.

State Registrar

DHMH 17 Rev 1/2001

Medical

ENKATA

and manner stated.

29c. License numbe

1) Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

10 07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29b. Signature and title of certific

4 ☐ Homicide

29a. Certifier (Check only one)

> 3 0 2007 OGT



		Please *	1
		For State	
40	0	Registrar  1. Decedent's Name (First, Middle, Las.	t
Physic	ian	DOROTHY	
/Medi		4a. Facility Name (If not institution, give	
Examin	ier	KESWICK MULTI - (	
Funeral		5. Social Security Number 6. Se	-
Director		029-22-9384	
D .		Usual Residence of Decedent	_
arylar show	_	10a. State 10b. County BALTIN	v
e Ma Ba-f :	cto		
ith th	Directo	10e. Street and Number	
ath v s 23a nust	ra	3801 SCHNAPER DI	1
er de Items	nu	11. Marital Status	
36 s aft ami	Ž	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	
hour hour al Es	edt	15. Decedent's Ed	
1215-0036 within 72 hours after death with the Marene. than "natural", or items 23a or 28a-f sl he Medical Examiner must be notified	plet	(Specify only highest grad	ā
212 I with giene r than	E	Elementary/Secondary (0-12)	
imore, Maryland 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural"; or Items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at	To Be Completed by Funeral	17. Father's Name (First, Middle, Last)	
/lar	2	MATTHEW	
ary and I		19a. Informant's Name/Relationship (7	)
and and n 27		MICHAEL BLUMENTI	ŀ
Ore		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐	
lim Pag		4 ☐ Donation 5 ☐ Other (Specify	
Baltimore, Maryland 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen	9
		Melf L	_
MIN.	ļ., .	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	0
Physician		Immediate Cause (Final disease or condition resulting in death)	
/Medical Examiner		resulting in death)	
4	_	Sequentially list conditions,	
ed sit	Jine	cause. Enter Underlying Cause (Disease or injury	
xecuter and Il-trans	Examiner	that initiated events resulting in death) Last	
'60, be exician sician buria			
587 ficate phys	gic		•
certi certi	Ž	IF FEMALE: 23b. Was decedent pregnant	
Beath Jeath	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	
the carrier	hysi	9 Unknown	
s that	V P	Part II. Other significant conditions of	C
rds quires n sign	Q Q		
w rec	lete		
Re Ir he Ir te has age 2	Juo		-
ital an: an: cor, p.	Ü	25. Was case referred to medical	-
ysich ysich is cer	0 8	examiner? 1 ☐ Yes 2 ☐ No	_
Division or Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transi	ertification: To Be Completed by Physician/Medical	27. Mann of Death	
ior andin ath. ir: Aff	atio	1 Vatural 5 Pending investigation	
Divisic lor Attend after death Director:	tific	3 Suicide 6 Could not be determined	3
	6		

Certificate of Death 2. Date of Death 25 October 2007 1:30 PM BLUMENTHAL 4c. County of Death street and number 4b. City, Town, or Location of Death CARE CENTER BALTIMORE 8. Date of Birth (Month, Day, Year) 03/24/1930 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country)
\_\_\_\_ Months Days Hours RI 10c. City, Town or Location 10d. Inside City Limits 10RE RANDALLSTOWN 1 □Yes 2 No 10g. Citizen of What Country? 10f. Zip Code RIVE #308 21133 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: U.S.A. 1 ☐ Yes 2 No Specify. Specify: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ication le completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) **HOMEMAKER** OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) **ANDRIESSE** EDITH STONE ype. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAL /\_SON 219 WOODBINE LANE - FAIRFIELD, CT. 06825 20b. Place of Disposition (Name of 20c. Location - City or Town, State MIKRO KODESH BETH Removal from State 10/28/2007 BALTIMORE, MD ISRAEL CONG SOL LEVINSON & BROS.. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 olications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Tetastatic new vendo cruse Mación Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 T Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed

Certification: To

Medical

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

29a. Certifier

1 Inpatient

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

2 ER/Outpatient 3 DOA

28b. Time of

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

N. IS BELLE

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 013657

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) October 25, 2007

State Registrar 31. Date filed (Month, Day, Year)

MARSREGOR, TOO W. 40 Th STREET, BALTIMORE, MD 21211 32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene State of Per FH G873 11/06/07/1H Certificate of Death Reg. No. 2 34688 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Oct. 2007 Catherine T. Bagdon 5:30 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dunda1k Eastpoint Rehab and Nursing Center Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 220-07-5772 30,1920 Director MD Mar. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" --- any injury or other traumatic events. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1.⊟Yes <del>2.∭</del>No BALL Funeral Director Baltimore City MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4418 Raspe Ave <del>21237</del> 21206 1501 Neighbors Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanley Bagdon Catherine M. Beruta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Russell-Sister 1501 Neighbors Ave Baltimore, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cemetery 10/31/07 | Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. Baltimore, MD 21206 6 6415 Belair Rd XV 23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pu **Physician** disease or condition resulting in death) /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation after death. 1 Yes 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SATPAL 5 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar OCT3 n 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6:10 PM **Physician** 27 2007 OCTOBER Martha Edna Cavey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE AGNES HOSP ITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) August 22,1932 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🔀 F Months Days Hours 213-30-5289 75 Maryland Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits or 28a-f show e notified at 10a. State 10b. County 1 XYes 2 ☐ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. o e 1207 Elmridge Ave 21229 USA ral", or items 23a Examiner must b by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced 'natural' White Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than the Tool Grinder Kaydon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked of traumatic ever William C. Cavey Mary E. Miller 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health : Nancy L. Yospa/Executor 1208 Elmridge Ave Baltimore, MD 21229 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc 10/29/07 | Baltimore, MD <sup>22</sup> Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228 21. Signature of Funeral Service Licensee C. Todd Dring 0. Tel, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC CARCINOMA **Physician** LUNG DNE YEAR /Medical Due to (or as a consequence of): Examiner YEARS SEVERE STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine physician and s the burial-transit resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy been signed by the atter Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 es 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has I page 2 s autops 1∐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation nours after death, neral Director; A: filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 21798 OCTOBER 27 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE BHAVANDEEP BAJAJ 31. Date filed (Month

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIFM/8, perFH C8/2 10/30/07 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) ) Ctober **Physician** CARTER 2:23 FRANCES ETTA 27, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** N/A Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birt 6/21/1934 9. Birthplace (State or Foreign (Month, Day) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 1 F 73 Yrs 1934 216-30-0147 Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lury or or other traumatic event, the Medical Examiner must be notified at 1 MYes 2 □ No Director Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21226 4200 Grace Court Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home 0 Dietician 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mood Hattie Bowen Eugene ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4200 Grace Court, Baltimore, Maryland 21226 (Son) William Barnes 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 10-30-07 Baltimore, Maryland Bayview Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Fugeral Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort Avenue, Baltimore, Maryland 21230 MIN r11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Stroke mmediate Cause (Final **Physician** 700 M disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 210 eizures Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hypertension

Due to (or as a consequence of): law requires that the death certificate be execuand Division or Vital Records. P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9∏Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1\□Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier October 27, 2007 38446 201 East niversity farkway 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) Jagadeesha NION 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death oct. 26 2007 Year **Physician** Laura J. Cortez /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Riverview Nursing Center Essex | If Under 14 Fig. | 8. Date of Birth | 9. Birthplace (State or Fig. | Months | Days | Hours | Min. | Feb. 24, 1915 | Louisanna 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 433-05-4663 1 □ M 2 □ ME 92 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10h County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1√2Yes 2□No Baltimore Baltimore MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7041 Bank Street 21224 USA Funeral ıral", or items 2 | Examiner mu Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Completed by Specify Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates: "natural", r than "natura the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Seamstress Elementary/Secondary (0-12) College (1-4or 5+) Clothing 8th 7 is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Schwarz Valentine Weaver ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Dorothy Kmoch 7043 Bank Street Baltimore MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of FaITH 11/1/2007 Rossville 5 Other (Specify) 21. Signature of uneral Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Cold Connelly Funeral Home of Essex implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on ear fline. 23a. P. 1. Enter the distase, or shock, or heart failure. Lis Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) eman ha **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4□Pregnant at time of death
9□Unknown Month Dav 5 ☐ Other (specify) ed by the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 triknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2⊟No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M-D 10-26-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLVD - MD - 21221. 709. MALIKA WASBERM BASTBRN

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

OCT 3 A 2007

many 1

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 U 0 7 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 /Medical 4c. County of Death Facility Name (If not institution, give street ar or Location of Death Examiner N/A 6. Date of Birth (Month, Day, FEB 12, If Under 1 Year Birthplace (State or Foreign Country) **Funeral** <sup>Year)</sup> 1953 Months Days 1 M 2 X F Yrs 54 Maryland 217-56-6318 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐Yes 2 X No Director Baltimore MD Arbutus 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1260 Brewster Street 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ Specify: 3 ☐ Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. the 12 Homemaker Own Home 7 Is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be C. Warren Bailey Audrey Dages 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health William L. Mathers, III, son 233 Dargun Road 21221 Essex, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If It any injury or c once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 10/26/07 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb Sec 299 Frederick Road BAltimore, MD 23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea d the death. Do not enter the mode of dving, such as cardiac or respiratory arrest Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed burial-tra physician 68760 Physician/Medical the as attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 mon Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown signed by t d be detach ut not resurt g in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Ď 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 perform this certificate 2 No 1∐ Yes 1 ☐ Yes 2 □ No or Vital or Attending Physician; Be Was case referred to examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Depatient 2 ER/Outpatient 3 DOA 2 funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) Division 1 Natural 5 ☐ Pending investigation 1 TYes 2 TNo death. neral Director: / 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide after To the Hospital o within 24 hours aft To the Funeral Di 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in a production of the cause of examination and or investigation in the cause of examination and or investigation in the cause of examination and or investigation in the cause of examination and or investigation and or 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month. Dav. Year)

DHMH 17 Rev 1/2001

State

Registrar

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ·\*/Medical or Location of Death Examiner 9. Birthplace (State or Foreign **Funeral** 15 15 Mary Land 1 □ M 2 🛛 F 74 Dec. 213-28-1281 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shor Examiner must be notified at X⊓Yes 2 □ No Director Baltimore MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important if the 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event the Marian 1 21230 United States 600 Light Street, Apt. 232 by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married Married Specify: White 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Burton Edward Joseph Charron 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4401. Fenor Road, Baltimore, MD 21227 19a. Informant's Name/Relationship (Type. Print) James R. Bowlin - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition □Burial 2XICremation 3 □Removal from State West Arundel Crematory10-31-2007 Odenton, MD Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Amerose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner S pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. Be Completed by 3 robably 4 □Unknown 2 No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 26. Place of Death Check onl o d to medical Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Man for of D 1 Deatural 2 ☐ Accident After 1 (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No t hours after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and Itle of certifier

State Registrar

Physicia /Medic Examin	al
LAdillil	ei.
Funeral	

Baltimore, Maryland 21215-0036

GRUCE CYRTIS

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

		ar 's Name <i>(First, Mid</i> ce Curtis	ddle, Last)			rtificate of E		2. Date of Death Month	Day Yea		
al			ion, give street and	number)		4b. City, Town, or	Location of Death	OCIOBO	4c. County of De		
er	8	-	ARIO ST			HAVRE de			HARFO	ORD	
	5. Social Se	curity Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. E	Birthplace (State or Foreign Country)	
	217-4	4-3546	1 M 2 □ F	60	Yrs.	Months Days	Hours Min.	May 27,	1947 Ma	ryland	
		ence of Decedent		140.00						10d. Inside City Limits	
_	10a. State	10b. Coun	nty	10c. Cit	y, Town or Lo	ocation				1 Tyes 2 No	
Director	MD	Harf	ord	Ha	vre de	Grace			000	Λ	
		and Number				10f. Zip Code	1070	10	g. Citizen of What USA	Country?	
Funeral		Ontario S		ecedent Ever in U	C 12		1078	ecity Ves of No-		merican Indian,	
ů	11. Marital	er Married 2 ☐ M	Armed	Forces?	.3.	Was Decedent of His If Yes, specify Cubar	Mexican, Puerto	Rican, etc.)	Black, W		
by		owed 4 🔀 Divorc	If Yes.	Give or Dates:		1 ☐ Yes 2 🎇 No	Specify:		Specify: V	white	
		15. Deced	ent's Education		16a. Dece	dent's Usual Occupa	tion	unk 1	6b. Kind of Busine	ss/Industry unl	
Completed	Flements	(Specify only high ry/Secondary (0-12	hest grade complete	e (1-4or 5+)	life.	kind of work done d DO NOT use retired)	uring most of work	ing			
Ë		2	0								
Be	17. Father's	7. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)									
ToE	Guy	Elwin Cu	urtis Sr				Fried	a Anna H	ecker		
	19a. Inform	ant's Name/Relatio	onship (Type, Print)		1	ng Address (Street a					
	Ke11	Kelley McLeod/niece 1426 Pebble Creek Drive Coppella, TX 75019									
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State										
'4 □Donation 5 Nother (Specify) in state											
	21. Signatu	re of Eunern Priori	ce Licensee	Director	: Si	Eate Anades	my a Board	655 W.	Baltimore	e Street	
	X	man	Mille		Ва	altimore,	MD 2120	1			
ner	Sequential	b.  Dusto (crass our sequence of):  Cause (Disease or injury hat initiated events esulting in death) Last  Due to (or as a consequence of):									
I Examiner	that initiate	d events	C								
ledical	IF FEMALE 23b. Was of in the	death) Last	c. Due d. 23c. If yes, 1 Lin 4 Pr		uence of): ancy I death 3[	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year	
Physician/Medical	IF FEMALE 23b. Was c in the	death) Last  Elecedent pregnant past 12 months? es 2 No	c. Due d. 23c. If yes, 1 Lin 4 Pr	to (or as a conseq outcome of pregna we birth 2 □ Feta egnant at time of d aknown	uence of): ancy I death 3[ leath 5[	Other (specify)	on in Part I.	23e. Did tob	Month		
by Physician/Medical	IF FEMALE 23b. Was c in the	death) Last  Elecedent pregnant past 12 months? es 2 No	c. Due d.  23c. If yes, 1 Lin 4 Pr 9 Ur	to (or as a consequence of pregnative birth 2 ☐ Feta regnant at time of disknown of death but not res	uence of): ancy I death 3[ leath 5[	Other (specify)	on in Part I.	23e. Did tob 1 □ Ye	Month acco use contribute	Day Year e to the cause of death?	
Completed by Physician/Medical	IF FEMALE 23b. Was of in the 1 Yeart II. Other	death) Last	c. Due d.  23c. If yes, 1 Lin 4 Pr 9 Ur  Ilitions contributing t	to (or as a consequence of pregnative birth 2 ☐ Feta regnant at time of disknown of death but not res	uence of): ancy I death 3[ leath 5[	Other (specify)		1  Ye  24a. Was ar autopsy perform 1 Yes 2	Month  acco use contribute s 2 No 3 T  And 24b. Were prior death And 1 T	e to the cause of death?  Probably 4 Unknown  a autopsy findings available to completion of cause of 1?	
Be Completed by Physician/Medical	IF FEMALE 23b. Was of in the 1 Yeart II. Other	death) Last	c. Due d.  23c. If yes, 1 Lin 4 Pr 9 Ur  litions contributing t	to (or as a consequence outcome of pregna ve birth 2 □ Feta egnant at time of dinknown odeath but not res	uence of):  ancy J death 3[ eath 5[ ulting in the u	Other (specify)	26. Place of Deal	1  Ye  24a. Was ar autopsy perform 1 Yes 2	Month  acco use contribute s 2 No 3   24b. Were prior deatr  X No 1   Y	Day Year  e to the cause of death?  ] Probably 4 □Unknown  e autopsy findings available to completion of cause of h?  Yes 2 No	
To Be Completed by Physician/Medical	IF FEMALE 23b. Was of in the 1 Ty 9 Tu Vename 25. Was care examinated and 1 Ty Ye 27. Mannea 1 Na Na 2 Ac	death) Last  death) Last  death) Last  death) Last  death) Last  death) Last  death pregnant past 12 months?  es 2 □ No nknown  er significant cond  se referred to medien?  s 2 □ No of Death ural 5 □ Pen cident inve	c. Due d.  23c. If yes, 1 Lin 4 Pr 9 Ur  litions contributing t  Vone  ical  Hospital: 1 28a. Da (Market)	to (or as a consequence outcome of pregna ve birth 2 □ Feta egnant at time of dinknown odeath but not res	uence of): ancy I death 3[ leath 5[	other (specify)  Inderlying cause give  Int 3 DOA Other  28c. Injury Work	26. Place of Deal	1  Ye  24a. Was ar autopsy perform 1 Yes 2	Month  acco use contribute s 2 No 3   24b. Were prior deatr 1 1   no 2	Day Year  e to the cause of death?  ] Probably 4 □Unknown  e autopsy findings available to completion of cause of h?  Yes 2 No	
Certification: To Be Completed by Physician/Medical	IF FEMALE 23b. Was of in the 1 Ty 9 Tu View of the common	death) Last  iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	c. Due d.  23c. If yes, 1 Liu 4 Pr 9 Ur  Ilitions contributing t  Vore  ical Hospital: 1 28a. Da (Management) defined 28e. Pl 28e. Pl	outcome of pregnave birth 2 Testa regnant at time of dinknown o death but not res	uence of):  ancy J death 3[ eath 5[ ulting in the u	other (specify)  Inderlying cause give  Int 3 DOA  Other	26. Place of Deat	24a. Was ar autops; perform 1 Yes 2 th Check onlone 5 Reside 28d. Describe ho	Month  acco use contributes 2 No 3   24b. Were prior death 1 1 1   acco use contributes 2 No 3   Contributes 2 No 3   Contributes 3 No	Day Year  e to the cause of death?  ] Probably 4 □Unknown  e autopsy findings available to completion of cause of n? Yes 2  No	
edical Certification; To Be Completed by Physician/Medical	IF FEMALE 23b. Was or in the 1  Y 9  U Part II. Other  25. Was careamin 1  Ye 27. Manner 1  Na 2  Ac 3  Sc 4  Hc	death) Last  Elecedent pregnant past 12 months? es 2 No nknown  Ser referred to mediar?  So 2 No of Death ural 5 Pen inverticide 6 Coumicide  For 1 Certification of 2 Medic	c. Due d.  23c. If yes, 1 Lin 4 Pr 9 Ur  litions contributing t  None  ical Hospital: 1 liding stigation 28a. Di (None)  liding stigation 28a. Di (None)  tying Physician: To cal Examiner: On the and no	outcome of pregnate birth 2 Testa egnant at time of disknown of death but not result to find the property of the best of my known the b	uence of):  ancy I death 3[ eath 5[ ulting in the u  ER/Outpatie 28b. Time c Injury ome, farm, st	other (specify)  Inderlying cause give  Int 3 DOA  Int	26. Place of Deat at ?? fes 2 □ No	24a. Was ar autops) perform 1 Yes 2 th Check onlone 5 Reside 28d. Describe ho 28f. Location (Str. City or Town and due to the cared at the time, da	Month  acco use contribute  s 2 No 3   24b. Were prior death 1	Day Year  e to the cause of death?  Probably 4 □Unknown  e autopsy findings available to completion of cause of n? Yes 2 No  Specify)  r Rural Route Number,  r as stated. due to the cause(s)	
Certification: To Be Completed by Physician/Medical	IF FEMALE 23b. Was or in the 1 Ye 9 U Part II. Othe  25. Was or examin 1 Ye 27. Mannel 2 Ac 3 Sc 4 Ho  29a. Certif (Chec one)	se referred to medier?  Se 2 No of Death ural 5 Pen cided invesioned ere 1 Certife conty 2 Medicuture and title of cert	c. Due d.  23c. If yes, 1 Lin 4 Pr 9 Ur  litions contributing t  None  ical Hospital: 1 liding stigation 28a. Di (None)  liding stigation 28a. Di (None)  tying Physician: To cal Examiner: On the and no	outcome of pregnive birth 2 Feta egnant at time of dinknown o death but not result to the basis of examination of	uence of):  ancy I death 3[ eath 5[ ulting in the u  ER/Outpatie 28b. Time c Injury ome, farm, st y)	other (specify)  Inderlying cause give  Int 3 DOA  Other  A 28c. Injury  Work  M 1 N  reet, factory, office  th occurred at the tim  vestigation, in my op  29c. License	26. Place of Deal	24a. Was ar autops) perform 1 Yes 2 th Check onl one 5 Reside 28d. Describe ho 28f. Location (Str. City or Town and due to the carred at the time, da	Month  acco use contributes  \$ 2 \int No 3 \int  24b. Were prior death 1 \int No  acco use contributes  \$ 2 \int No 3 \int  24b. Were prior death 1 \int No  acco use contributes  \$ 2 \int No 3 \int  24b. Were prior death 1 \int No  acco use contributes  \$ 2 \int No 3 \int  24b. Were prior death 1 \int No  acco use contributes  \$ 2 \int No 3 \int  24b. Were prior death 1 \int No  acco use contributes  \$ 2 \int No 3 \int  acco use contributes  \$ 2 \int No 3 \int  acco use contributes  \$ 2 \int No 3 \int  acco use contributes  \$ 2 \int No 3 \int  acco use contributes  \$ 2 \int No 3 \int  acco use contributes  \$ 2 \int No 3 \int  acco use contributes  \$ 3 \int No 3 \int  acco use contributes  \$ 4 \int No 3 \int  acco use contributes  \$ 4 \int No 3 \int  acco use contributes  \$ 4 \int No 3 \int  acco use contributes  \$ 4 \int No 3 \int  acco use contributes  \$ 5 \int No 3 \int  acco use contributes  \$ 5 \int No 3 \int  acco use contributes  \$ 6 \int Other (S)  winjury occurred  acco use contributes  \$ 6 \int Other (S)  acco use	Day Year  e to the cause of death?  Probably 4 Unknow  e autopsy findings available to completion of cause of the cause of	

State Registrar

OCT 3 0 2007

State of Maryland / Department of Health and Mental Hygiene Of Techniques of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0720 A M CTUBER **Physician** ALVIN F COCHRAG /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) **Examiner** HAGE ESTOWN WACHINGTON MCIH If Under 1 Year If Under 24 Hrs. Min. (Month, Day, Sept 28, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 € M 2 □ F 65 213-42-8916 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County rthen "naturel", or Itame 23a or 28a-f show the Medical Examiner notes be rediffed at 1 ☐ Yes 2 🕅 No Hagerstown Washington Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21746 18601 Roxbury Road Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: white Maryland 21215-0036 þ 3 ☐ Widowed 4 ☑ Divorced unk Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygient Important: if item 27 is marked other the eny injury or other traumatic unk unk unk 18. Mother's Name (First, Middle, Maiden Sumame) unk 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18601 Roxbury Road Hagerstown, MD MCI Hagerstown Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) in State 21. Signature (Euneral Service License Ronald Service Director Ronald Service Director State Anatomy Board 655 W. Baltimore, MD 21201

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC MELANDMA Physician /Medical Due to (or as a consequence of) Examiner ACITE sides and the state of the stat Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? ŏ 5 Other (specify) ☐Yes 2 ☐ No P.0. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? been signed the should be determined to the should be determined to the should be determined to the should be should Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were aulopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No certificate Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) INFIRMA Hospital: 1 ☐ Inpatient examiner: 1 Xes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 3 Suicide 4 - Homicide To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical th 0 29c. License number 29b. Signature and title of certifier ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALI MCIH HAGE KA KESH 32. Registrar's Signature 31. Date liled (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/200

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** annon 25 2007 0 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Baltimore Jospita 8. Date of Birth (Month, Day, Year) 12-27-1953 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Months Hours Min 1**X** M 2□ F ·Carolina **Director** Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at show 1 ☐ Yes 2 No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be re 3 death v Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ears Honore 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Zencore Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2310 Rosedaje Moller DKe Irainia HOII 20b. Place of Disposition (Name cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 R Department of Important: If It any Injury or o once. 3 Removal from State 21. Signature of Funeral Service Licensee eroices 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** POXLO /Medical Due to or as a consequence of): Examiner 45 min Sequentially list conditions, Language to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 No 3 Probably icate has been a 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 ER/Outpatient 3 DOA ပ 1 ☐ Inpatient After this 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury within 24 hours arter co... To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

A

State Registrar 30. Name and address of person who completed cause of death (Ite

Year

C

John

31. Date filed (Month, Day,

45

Choice DrivE Baltimora

23a) (Type, Print)

8

32. Registrar's Signature

			State of Maryland / Dep	artment of Health an	d Mental Hyg	jiene							
		_ 1	1 - State Registrar	rtificate of Death	R	leg. No.2 117 34697							
	Discoulation in the second		Decedent's Name (First, Middle, Last)		Date of Dea     Month	Day Year							
	Physicia /Medic	al .	Ralph E. Caudle, Sr.		October								
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of D	Death	4c. County of Death							
			Montgomery Hospice Casey House  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday	Rockville If Under 1 Year   If Under 24	Hrs. 8 Date of Birth	Montgomery  9. Birthplace (State or Foreign							
	Funeral Director	1	233-34-9075 1 M 2 F 80 Yrs.		Hrs. 8. Date of Birth (Month, Day Jan 5 5	(Year) Country) 1927 West Virginia							
17	_	1	Usual Residence of Decedent		,								
	ylanc how at		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits 1 ☐ Yes 2 🄀 No							
	e Ma 3a-f s tified	턍	Maryland Montgomery Rockville										
	or 28	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?							
	s 23a		4913 Bluebonnet Court  11 Marital Status 12, Was Decedent Ever in U.S. 13	20853 Was Decedent of Hispanic Origin		United States  14. Race - American Indian,							
	ter de Item	Funeral	Armed Forces?	If Yes, specify Cuban, Mexican, F	uerto Rican, etc.)	Black, White, etc.							
39	be filed within 72 hours after death with the Maryland tral Hyglene.  Id other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates: 1951-75	1 ☐ Yes 2 ☑ No Specify:		Specify: White							
21215-0036	2 hou		15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giy	edent's Usual Occupation	f working	16b. Kind of Business/Industry							
218	within 7 iene. than "r he Med	Completed	Elementary/Secondary (U-12)   College (1-401 5+)	e kind of work done during most of \$91001vedeti@ffficer									
21	filed wi Hygien Ither th	S		er Pilot	Name (First, Middle,	U.S. Air Force							
pu	be fill tall H d oth	Be	17. Father's Name (First, Middle, Last)										
Maryland	should be tand Mental somewhele of marked or umatic even	ဥ	David W. Caudle  19a. Informant's Name/Relationship (Type. Print)  19b. Mai	ing Address (Street and Number of	e Catherin or Bural Route Numbe	<u> </u>							
Ma	d 2 sl th an th an 17 is r traur					e, Maryland 20853							
di.	es 1 and 2 should b of Health and Ment f Item 27 is marked ir other traumatic e		20a. Method of Disposition 20b. Place of Disposition		Date	20c. Location - City or Town, State							
JO L	Pages ent of nt: If I		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	i i	n. 14, 2008	Arlington, Virginia							
Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.					Home/Rockville, Inc.							
m	P E E		M00896 3	00 W. Montgomer	y Ave., Ro	ckville, MD 20850-2805							
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure). List only one cause on each line.											
	Physician		nmediate Cause Final End stage Chronic Obstructive Pulmonary Disease										
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	Due to (or as a consequence of):									
	Lxaiiiiiei	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):										
1	ted nsit	nine	Cause (Disease or injury										
M.	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last c										
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dical	d										
9	tificat ng phy as th	ledi	-										
Box	death certific attending p	an	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death	☐Ectopic pregnancy		23d. Date of delivery  Month Day Year							
	e dea the at	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	Other (specify)									
P.0	uires that the de signed by the a d be detached to	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	obacco use contribute to the cause of death?							
ds,	ires t signe	by	Non Hodgkins Lymphoma	, ,	1 🗆 `	Yes 2 No 3 Probably 4 Nunknown							
ő	w requir	Completed by			24a. Was	an 24b. Were autopsy findings available							
Rec	has ge 2	шb			autor perfo	psy prior to completion of cause of death?							
a			25. Was case referred to medical	26. Place o	1□ Yes of Death Check onlo	21⊠No 1 ☐ Yes 2 ☐ No							
or Vital Records,	Physician: The law this certificate has I al director, page 2 s	To Be	examiner? 1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	Othor		Inpatient dence 6 ©Other (Specify) Hospice							
0	<u>a</u> + e		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)		28d. Describe	how injury occurred							
ior	Attending r death. ector: After by the fune	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No									
Division	or Atterder de directe	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (: Cify or To	Street and Number or Rural Route Number, wn, State)							
Ω	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f		29a. Certifier 1 \(\mathbb{N}\) Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and	place, and due to the	cause(s) and manner as stated							
	Hosi 24 ho Fune stely f	Medical	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, de (Check only one) and manner stated.	investigation, in my opinion, death	n occurred at the time,	date and place, and due to the cause(s)							
	o the	Mec	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)							
	<b>⊢</b> ≶ <b>⊢</b> ō		Devenire Wid Ceno	D00646	/5	October 29, 2007							
	- 11		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	, –								
_	104,		Genevieve Anne Wroblewski, M.D., 600	l Muncaster Mil	1 Rd., Roc	kville, MD 20855							
		ate	31. Date filed (Month, Day, Year)  OCT 3 0 2007  32. Registrar's Signature	made									
	Regist	rai	OOI & O LOO! Description										

DHMH 17 Rev 1/2001

				icase i	State of Marylan	d / Denartm	ent of Health and	Mental H	/giene	LOGIDIO.	
		•	For State Registrar		olato ol Marylan	•	ate of Death		Reg. NZ	007	34698
	Dhu eisi		1. Decedent's Name (First,	Middle, Last)	D		1 18	2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia /Medic		Lames		Dernard	. Ca	mpbell	10	26	07	10:30 p.M
	Examin	er	4a. Facility Name (If not ins	. /	. //	4b. C	ity, Yown, or Location of Deal	~	4c. (	County of Dea	ıth
40	Funeral		5. Social Security Number	6. Sex			der 1 Year If Under 24 Hrs	8. Date of B	irth	9. Bir	thplace (State or Foreign
×	Director		218.03.50	/	M 2 F 88	Yrs. Mont	ns Days Hours Min	(Month, E	1/19		MD
	land	}	Usual Residence of Decedor 10a. State 10b. C		10c. Ci	ty, Town or Location			,		10d. Inside City Limits
	Mary	tor	MD		3	altimo	YE_				Yes 2□No
	or 28	Director	10e. Street and Number	1 100		10f.	Zip Code		10g. Citiz	zen of What Co	ountry?
	be filed within 72 hours after death with the Maryland Hygiene. d other then "naturel", or items 23a or 28a-f ehow event, tre Medical Examinat must be notified at	erai	2000		Sion Str	EET 13 Was D	2/2/	Spacific Vas or N	100 1	14. Race - Ami	erican Indian
_	ifter d	Funeral	11. Marital Status 1 □ Never Married 2	,	Armed Forces?  1 X es 2 No If Yes, Give		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puel	rto Rican, etc.)		Black, Whi	
5-0036	hours after turel', or ite al Evelti or	d by	3 ☐ Widowed 4 ☐ Div	orced	If Yes, Give Year or Dates:	1 □ Ye	s 2 No Specify:			Specify:	black
7	n 72 h "natu edica	Completed	15. De (Specify only	cedent's Educ highest grade			Isual Occupation work done during most of wo Tuse retired)	orking		nd of Business	_
212	filed within 72 Hygiene. ther then "nai the tre Medic	ошо	Elementary/Secondary (	)-12)	College (1-4or 5+)		rK		A	CME	
9	should be filed with and Mental Hygiene marked other the imatic event, tra	Bec	17. Father's Name (First, M	iddle, Last)	1-11		A /	me (First, Midd	le, Maiden	Sumame)	
Maryland		မ	Joshua		riphell	405 Mailine Add	Mag	1	tau	) Fins	Žia Coda)
<u>a</u>	2 a i a i a		19a. tnformant's Name/Re	ationship (1)	(Spouse)	7 OOO	ess (Street and Number or F	11 7	3c H:	NAS	Zip Code) MD 21217
ē,			20a. Method of Disposition	Spiser		Place of Disposition (cemetery, crematory	Name of	Date	20c. Lo	cation - City or	
Baltimore,			1 Burial 2 Crem		emoval from State	voisin tare	st VA cemetary	10/3/07	Ow	ings N	lills MD.
aalt	permit. Pag Department Importent: I eny injury c		21. Signature of Huneral S		He	22. Name	and Address of Facility	ungal-	Home	E.P.A.	10 31-11
100	40200			ase, or compli	cations that caused the dea	th. Do not enter the	22 W. Nor Yh	AUEN.	arrest,	34170	Approximate Interval Between
	Physician										
1	/Medical Examiner		resulting in death)		Due to (or as a consec		30030				
*	~ Cxammer	7	Sequentially list conditions if any, leading to immediat cause. Enter Underlying	. I t	Due to (or as a consec	quence of):					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	` ⊀	240 10 (07 43 4 201.300	4501150 01).					
Ō,	te be executed ysicien and e burial-transit		resulting in death) Last		Due to (or as a consec	quence of);					
68760		dicai			l				· · · -		
ox e	certifi nding use as	Physician/Med	IF FEMALE: 23b. Was decedent pregn	ant 2	3c. If yes, outcome of pregn					23d. Date of de	alivery
n	death se atte	sicia	in the past 12 months 1 ☐ Yes 2 ☐ No		1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of a 9 ☐ Unknown		c pregnancy (specify)		-	Month	Day Year
о. О	The law requires that the death certifical sie hes been signed by the attending phyage 2 should be detached for use as the	Phys	9 Unknown	anditions oor	ntributing to death but not re-	culting in the underhi	ng equip gwee in Root I	23e Di	d tobacco u	se contribute	to the cause of death?
Division of Vital Records,	w requires that been signed be should be det	d by	raitii. Other arginioant o	ondruona cor	mbutang to death but not re-	saiting in the underly	ig cause given in Fait.		Yes 2	-	Probably 4 Unknown
S	sw req	Completed			,			24a. W		24b. Were a	autopsy findings available ocompletion of cause of
E	sician: The law s certificete hes b lirector, page 2 s	omi						au pe 1 ☐ Yes	topsy rformed? 2 No	death?	s 2 No
/ita	Physician: r this certifice ral director, j	Be	25. Was case referred to reaminer?	-				eath (Check onl			
o	Physi this c ral dire	٠ <u>.</u>	1 ☐ Yes 2 ☐ No  27. Manner of Death		lospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient 3		Home 5 ☐ Re			ecify)
o	Attending Prices of death.	ation	1 Natural 5	Pending investigation	(Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	200. 2000/10	0 11011 111,01	, 000000	
N N	or Attendented of the Colors o	Certification:	3 ☐ Suicide 6 ☐	Could not be determined	28e. Place of Injury - At I building, etc. (Spec		ctory, office	28f. Location City or	(Street an	d Number or F	Rural Route Number,
	To the Hospitel or Attending Physician: The within 24 hours eliter death.  To the Funerel Director: After this certificete he completely filled in by the tuneral director, page		20a Cartilla	514.1							
	P Hosi 24 ho Funda etely f	Medicai	29a. Certifier 1 C (Check only 2 M	edical Exami	ner: On the best of my kn ner: On the basis of examin and manner stated.	ation and/or investiga	red at the time, date and plaition, in my opinion, death oc	ce, and due to the curred at the tim	ne cause(s) e, date and	and manner a I place, and di	as stated. ue to the cause(s)
	To th within To th comp	Me	29b. Signature and title of	Straig.			29c. License number			-	nth, Dey, Year)
)			1000	XXX	68		12005333	7	10	2910.	7
	3		30. Name and address of		mpleted cause of death (Ite		Avenue Su	te 203	Bal	trume	7 -1 Md 21209
(200 <sub>3</sub> )	Sta	ate	31. Date filed (Month, Day	Year)	32. Raistrar's Sign			,, ,,,		1.	1
200	Regist		OC1	3 0 20	107 Balliago	S. Suga					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2007 24, 8:00 Ernest Franklin Chelton Oct. A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 39 1/2 Greenwood Ave Overlea Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept. 3, 1927 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours 1 XM 2 ☐ F 80 219-10-5125 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ones. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Director MD Baltimore Overlea 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 39 1/2 Greenwood Ave 21206 USA Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐**X**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐XNo Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Worker Lever Bros 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Chelton Emma Murphy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Chelton-Wife 39 1/2 Greenwood Ave Overlea, MD 21206 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/29/07 Dulaney Valley Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 21. Si viature of Funeral Service Licensee Baltimore, MD 21206 6415 Belair Rd se or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bist only one cause on each line. 23a. Part . Enter the disagnetic hook, or heart failure . Immedi e Cause (Final disease or condition resulting in death) unt? Physician ebility /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uisease or night) that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 No , oshomelih 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: (Month, Day Year) Injury 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No M 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital within 24 hours at To the Funeral

Baltimore, Maryland 21215-0036

ipital or Attending Physician: The law requires that the death certificate be executed ours after death.

The law been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit

h

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARREN 31. Date filed (Month, Day, Year) State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

J. CHMUES in 6701N Charks

2007

32 Registrar's Signature

Registrar

🚅 CertifyIng PhysIcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

ST PONSUN SNO 21209

29d. Date signed (Month, Day, Year) OCTUSE 26 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 7 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death C to be Alberto Year **Physician** ArIA 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Samare Hosbita da If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Country) Months Days Hours Min. 1 ■ M 2 🔭 F 215-12-5683 1920 Director 15 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director OSCDALC KOSC DALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 U-S-A Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No land 21215-0036 Specify þ White 3. Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 8+1 onenAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SCMA ٩ AUCRIO 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2506 Alfred A1005A INKSburg 21048 0 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - Oity or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify) Entonoment BALTINGE HARYLAND 11-3-2007 22. Name and Address of Facility NNING HD ZIZZ 4 Conkling St. DAIN 23a. Part1. Enter he disease shock, or fleart failure Approximate Interval Between Onset and Death e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 1 TYes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 21 No certificate 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred TH-Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lo, 2007 who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)
OCT 3 0 2007

Franklin

32. Registrar's Signature

			1 - For State Registrar	State of Ma	ryland		artmen <i>tificat</i>					giene	007	3470	
	Physici /Medio		1. Decedent's Name (First, Middle, Last	Melb	a	Vo.	rse4				2. Date of Dea Month	Day	Year	3. Time of De	eath M
	Examin		4a. Facility Name (If not institution, give Augsburg Luther	street and number) can Nurs:	ing	Home	4b. City,	Bal	time	ore			ounty of Dea		
	Funeral Director		5. Social Security Number  213-16-3918  Usual Residence of Decedent	TH OFF	(In yrs. 1. 90	ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	B. Date of Birt (Month, Da )6 18	y, Year	9. Bir	nthplace (State or Fe ountry) MD	oreign
	he Maryland 8a-f show offlind at	ector	10a. State 10b. County NA			,Town or Lo Ba <b>lti</b> I	nore							10d. Inside City L	
	h with th	al Dire	10e. Street and Number 6311 Campfield	Road			10f. Zip		207				on of What C		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I're Medical Exa. if refreshed to incilling at ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		1	Was Deced f Yes, spec 1  Yes		spanic Or n, Mexical Specify:		cify Yes or No lican, etc.)	1	Race - Am Black, Whi		
21215-0036	J within 72 ho jene. r than "natui ine Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th grade	ucation de <i>completed)</i> College (1-4or 5- na	+)		dent's Usua kind of wo DO NOT us CCOU!	rk done d se retired,	uring mos	st of workin	g		of Business	Dept. Si	tor
Maryland 2	should be filed within and Mental Hygiene.  marked other than " umatic event, the Market	Be	17. Father's Name (First, Middle, Last) George Oliver V	ascoe Jo	nes				Ann	ie Jo					
Mar	nd 2 sho alth and 1 27 is me ir traume		19a. Informant's Name/Relationship (7) Lauretta Dorsey		iece		ng Address	(Street a	nd Numb	er or Rural Road	Route Number	er, City or	Town, State,	Zip Code) Md 2121	4
Baltimore,	Pages 1 a nent of Hez int: If item iry or othe		20a. Method of Disposition		C	lace of Dispo emetery, crer outus	natory or o	ther place		Da 11/2,	/07		ation - City o	r Town, State Md	
Balti	permit. Departm Importa any inju		21 Signature of Funeral Service Licens	. Dud	W	M <sup>2</sup>	Name ar arch 300	F/F Waba	s of Facili We ish	št Ave,	Balt:	imor	e, Md	21215	
	Physician /Medical		23a. Part 1 Enter the disease, or comp shoot, or heart failure. List only of Immedia- Cause (Final disease or condition resulting in death)	ne cause on each lin	3+4h	elosde					respiratory a	1	usc	Approximate Interval Between Onset and Dea	en ath
8760, 1	certificate be executed  Thing physician and  Lise as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease of injury that initiated events resulting in death) Last	b. Due to (or as a	a consequ	uence of):									
.O. Box 68	death certifii e attending p od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 🗀 Fetal	Ideath 3□	□Ectopic pi □ Other (sp					23	d. Date of de Month	elivery Day Yea	ar
Φ.	98 90 90	þ	Part II. Other significant conditions co	entributing to death bu	it not resi	ulting in the u	nderlying o	ause give	n in Part	1.		obacco us Yes 2		to the cause of dea Probably 4 □Unk	
Division of Vital Records,	The law ate has b	Completed									24a. Was auto perio 1 🗆 Yes		death?	autopsy findings ava completion of causes	ailable se of
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	_		(Check only o		CO::		
ion of	fte ng	ation; To	1 Yes 2 No  27. Manner of Death 1 SNatural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y	28b. Time o Injury		28c. Injury Work	4 11	2	ne 5 Resi 8d. Describe			өсіту)	
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	iry - At ho c. (Specify	ome, farm, sti	reet, factor	, office		2	8f. Location ( City or To		Number or I	Rural Route Numbe	er,
	Hospii 24 hour Funera etely fille	edical (		/sician: To the best of iner: On the basis of and manner sta	examina										
	To the within To the	Me	29b. Signature and title of certifier				29	c. License						nth, Day, Year)	-1
,	2		30. Name and address of person who	completed cause of de		n 23a) (Type,	Print)	ا د لمدره	stor	573	Mo	211		29,200	/
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	iture	and to	~*··	23100		-				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M		nd / Depa	artmer		ealth and	Mental Hy		2007	34702
	Physic /Medi		Decedent's Name (First, Middle, La     Phyllis Douglas	ast)						2. Date of De Month	ath Day		3. Time of Death 5:40 PM M
>	Examir		4a. Facility Name (If not institution, git 4400 East West		23	-		Town, or	Location of Dea		4c.	County of Death	h
	Funeral Director		5. Social Security Numbeunk 6.			last birthday) Yrs.	If Unde	Days	If Under 24 Hr. Hours Mir		th ly, Year)	9. Birtl	hplace (State or Foreign untry) nada
	Maryland f show	jo	Usual Residence of Decedent	merv	10c. Cit	y, Town or Lo Beth							10d. Inside City Limits 1 ☐ Yes 2√ No
	a or 28e	I Direc	10e. Street and Number 4400 East West H	-	1		-	p Code	R1 4			en of What Co	
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hyglene. Importent: If item 27 is marked other then "natural", or Items 23a or 28e-f show styl injury or other treumatic event, tra Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes, Give Year or Dates:			Was Dece f Yes, spe 1  Yes	dent of His		Specify Yes or No rto Rican, etc.)	)- 1	4. Race - Ame Black, White Specify: Wh	e, etc.
1215-0	within 72 ho ine. hen "natur i Medical	mpleted	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or t	5+)	16a. Deced (Give life. L	kind of w	ial Occupat ork done du se retired)	tion uring most of wo	orking	16b. Kir	nd of Business/l	Industry
Maryland 21215-0036	ild be filed viental Hygie ked other t ic event, to	To Be Co	12 17. Father's Name (First, Middle, Last David Kelly Dou	•			_pha	rmaci	18. Mother's Na	ame (First, Middle Niven Ma	, Maiden :		re
	and 2 shoulelth and Miselth an		19a. Informant's Name/Relationship	Type, Print)		19b. Mailin	ng Addres	s (Street ar		NIVEIT MA			<sup>(ip Code)</sup> unk
Baltimore,	ment of H tent: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 最Other (Speci	m in state	C	Place of Dispo emetery, cren	natory or	other place		Dale		cation - City or	
						1 tim	ore.	MD 212	d 655 W. 01		timore		
	Physician /Medical Examiner	er	shock or hear failure. List only Immediate Oause (Final disease or condition resulting in dealth)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to (or as	a consequ	uence of):	er the mo	se or dying.	, such as cardia	ac or respiratory a	rrest,	Ø	Approximate Interval Between Onset and Death
8760,	cate be executed physiclen and the burial-transit	dical Examiner	causé. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as									
.O. Box 6	The law requires that the death certificat ite has been signed by the attending phy age 2 should be detached for use as the	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	Ideath 3□	Ectopic p				2.	3d. Date of deli Month	very Day Year
ords, P	w requires thet the de been signed by the should be detached		Part II. Other significant conditions (	contributing to death b	ut not resu	ulting in the ur	nderlying	ause giver	in Part I.		obacco us Yes 2		the cause of death?
Vital Records,		Completed								24a. Was autor perfo 1 Yes		prior to c death?	topsy findings available completion of cause of
<b>5</b>	nysicien: nis certifica director,	o Be	25. Was case referred to medical examiner? 1. ★Yes 2 □ No	Hospital:				Other		ath (Check only o			
ion of	Ing Pt Viter th	atlon: To	27. Manner of Death  12. Natural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Da	ry	ER/Outpatien 28b. Time of Injury		28c. Injury a Work?	4 🗀 Nursing i	Home 5 Residence 1			1fy)
Division	ital or Attendurs efter death	Certification:	3 Suicide 6 Could not be determined	building, etc	c. (Specify	·)				City or To	vn, State)		ral Route Number,
	To the Mospital or Attendi within 24 hours effer death To the Funeral Director: A completely filled in by the t	Medical	29a. Certifier (Check only one)  1 Certifying Properties 2 Medical Example 12 Certifier 29b. Signature and title of certifier	nysicien: To the best niner: On the basis of and manner sta	examinai	wledge, death tion and/or inv	estigation	at the time i, in my opin c. License	nion, death occ	urred at the time,	date and	place, and due	to the cause(s)
	F 3 F 8		of a met			DME	- 1	700	728	5,	0 1	signed (Month	2007
			30. Name and address of person who	completed cause of d	eath (Item	23a) (Type, I	Print)		( 8n e		mc	12 121	902
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 3 0 2	32 Registra	ar's Signa	ture Aos	White I		f		,,,		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 5:03 AM 25 2007 THER OCTOBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL BALTIMORE
If Under 1 Year | If Under 24 Hrs. HARBOR 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours 1**X** M 2□ F Virginia Director 83 230-14-2217 11-23-1923 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show idkal Examiner must be notified at 1 Yes 2 No Director MD. **Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with Hygiene. U.S.A.

14. Race - American Indian,
Black, White, etc. by Funeral 21225 313 Bridgeview Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1943-1946 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private 4th Steel Worker If item 27 is marked other or other traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental ဥ William E. Day

19a. Informant's Name/Relationship (Type. Print) Annie Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4336 Gilmer Ct.Bel Campe, MD 21017 Larry Plenty-Walls
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important; If any injury or once. heathville, VA Heathville Ch.Cem. 11/01/07 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ronald Taylor II Funeral Hm. Konald do 108 West North Ave.Baltimore,MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY KO HOURS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 1 TVas 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown tteART Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an DABETES page 2 autopsy performed has certificate 1∐ Yes 2 - No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

7

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300 i

gistrar's Signature

NICHOLAS A.R

31. Date filed (Month, Day, Year)

	1	State of Maryland / Department of Health and I  State of Maryland / Department of Health and I  Certificate of Death	Mental Hygier Reg. 1	7001 34104
Physici /Medic	an	1. Decedent's Name (First, Middle, Last)  Helen Ensor Eldridge	Oct. 26	
Examir	er	4a. Facility Name (If not institution, give street and number)  Stella Maris Hospice  F. Social Security Number.  16 Sex   7. Age (In vrs. last birthday)   If Under 1 Year   If Under 24 Hrs.	8 Date of Righ	4c. County of Death  Baltimore  9. Birthplace (State or Foreign Country)
Funeral Director	-	216-38-3593 1 M Z F 85 Yrs. Months Days Hours Min.	Dec. 8 19	21 Country) MD  10d. Inside City Limits
ne Marylan 8a-f show otified at	ctor	MD         Baltimore         Timonium           10e. Street and Number         10f. Zip Code	100.0	1   Yes 2   No
h with th		10e. Street and Number 1226 Roundwood Rd. #318 21093		USA
ine, intally failed KIKI Shous after death with the Maryland is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fur	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes ② No If Yes, specify Cuban, Mexican, Puer  1 □ Yes ③ No If Yes, Specify:  1 □ Yes ③ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: white
d within 72 hours af glene. er than "natural", or the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  10  16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)  Sales		. Kind of Business/Industry  Retail
ould be filed v Mental Hygie narked other i	Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name	me (First, Middle, Maid	
d 2 should be flie th and Mental Hy ?? is marked oth traumatic event	2	Lester Chilcoat Ensor Jodie  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Relationship)		ty or Town. State, Zip Code)
1 and 2 sh Health and em 27 is n		Barbara A. Jones/daughter 14824 Thornton Mill F		
permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Black Rock Cemetery 10		Location - City or Town, State
permit. Departm Importa any Inju		21. Signature of Funeral Service treessee  22. Name and Address of Facility  Lemmon Funeral Hom  10 W. Padonia Rd.,	ne of Dulan	ney Valley, Inc. MD 21093 Approximate
death certificate be executed / Medical Exammine and dror use as the burial-transit	by Physician/Medical Examiner	23a. Part1. Eye the disease, or confications hat caused the death. Do not enter the mode of dying, such as cardial shock, if he if failure. List only one cause in each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	Interval Between Onset and Death	
death certif e attending d for use a	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of delivery  Month Day Year
requires that the een signed by the nould be detache	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 😾 Unknown
The la ate has page 2	Completed		24a. Was an autopsy performed 1  Yes 2 <b>X</b>	24b. Were autopsy findings available prior to completion of cause of death?  No 1   Yes 2   No
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 2 No Other: 4 Nursing	28d. Describe how	et and Number or Rural Route Number,
e Hospital 24 hours e Funeral etely filled	Medical Co		ce, and due to the causecurred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
To the To the comple	Me	29b. Signature and title of certifier  29c. License number		Date signed (Month, Day, Year)
4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM	4, MD 21093	
S Regis	ate trar	31. Date filed (Month, Day, Year)  OCT 3 0 2007		

DHMH 17 Rev 1/2001

OCTOBER 1:29 p.m.

HELEN ELDRIDGE

Division or Vital Records, P.O. Hospital or Attending 24 hours after death. Director: To the Hospital of within 24 hours all To the Funeral D

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

orac

Year 3 0

31. Date filed (Month, Day,

Registrar

Certification:

Medical

		•	State of Maryland / Dep. State of Maryland / Dep. State of Maryland / Dep. Ce	artment of Health and M rtificate of Death		2007 34706		
ā.	Physicia		Decedent's Name (First, Middle, Last)     LILLIAN P FERRELL		Date of Death     Month Day	3. Time of Death		
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death		
- 30 - 3		•	Genesis Hammonds Lane	Brooklyn Park		Anne Arundel		
,	Funeral Director		5. Social Security Number  6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 17,19	9. Birthplace (State or Foreign Country) Virginia		
	ס		Usual Residence of Decedent		reb. 17,19			
	larylar show ed at	ō	10a. State10b. County10c. City, Town or LowMarylandAnne ArundelGlen Bur			10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
	the N	Funeral Directo	10e. Street and Number	10f. Zip Code	10g. Citi	zen of What Country?		
	h with	a D	281 Cross Creek Drive	21061	U	U.S.A.		
	ems (	iner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sport Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.		
30	rs afte	Σ.	1 Nover Married 2 Married 1 Vec 2 No	1 ☐ Yes 2 No Specify:		Specify:		
2-003p	2 hou latura ical E	ted	15. Decedent's Education 16a. Dece	edent's Usual Occupation	White 16b. Kind of Business/Industry			
7	ithin 7 ne. nan "n Medi	Completed by	Flementary/Secondary (U-12)   College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)		Electric 9 December		
Z	filed w Hygiei ther th	ပ္	1Z Z C	18. Mother's Name	V A •	Electric & Power		
yland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	Walter Ellyson Quisenbe		Pear1	Stover		
Mary	and N is mai		19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Number or Run	al Route Number, City o	r Town, State, Zip Code)		
e) E	and 2 Health m 27 her tr			Cross Creek Drive		-		
20	ages 1 nt of H : If ite		I   Bunal 2 Micremation 3   hemoval from State	ematory or other place)		ocation - City or Town, State		
baitimor	nit. Parantme ortani injury			Crematory 10/29 2. Name and Address of Facility		imore, Maryland		
ă	permi Depa Impo any ir once,		At I Allin	2. Name and Address of Facility McCully—Polyniak F 3204 Mountain Road	uneral Home Pasadena,	e, P.A. Maryland 21122		
			23a. Party: Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death		
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)			Onset and boats		
	Examiner		Due to (or as a consequence of):					
E	# # #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying					
1	be executed ician and burial-transit	Examiner	Cause (Disease or Lifury that initiated events c					
<b>68/6</b> 0,	ate be executed hysician and the burial-transit	ical E	bue to (or as a consequence on).					
	death certificate e attending phys d for use as the							
gox	ath cer tendin or use	an/N	IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome pf pregnancy   1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy	1	23d. Date of delivery  Month Day Year		
	w requires that the death certifics been signed by the attending phe should be detached for use as the	Physician/Med	in the past 12 months?  1   Yes 2   No 9   Unknown	Other (specify)		Month Bay roa		
7.	requires that the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?		
cords,	equires en sig ould be	ed b	Advanced Dementia	-	1 ☐ Yes 2	□ No 3 □ Probabły 4 🔼 Unknown		
ecc	law re las be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
<u>=</u>	it The	Con			performed? 1□ Yes 2♣No	death?		
VITA	siciar certif	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Lau	h (Check only one)	2 Floring (0 - 1/1)		
0	g Phy er this eral d	$\vdash$	27. Manner of Death 28a. Date of Injury 28b. Time	AL SUBOA 4 Nursing Ho	ome 5 Residence 28d. Describe how injur			
200	endin sath. or: Af the fur	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No				
UIVISION	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filed in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street an City or Town, State	nd Number or Rural Route Number, e)		
	spital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the cause(s	) and manner as stated.		
	the Ho iin 24 h the Fu	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or one) and manner stated.					
1	Veith To 1	Σ	29b. Signature and title of certifier	29c. License number		te signed (Month, Day, Year)		
}			30. Name and address of person who completed cause of death (Item 23a) (Type	D53462	•	10/29/07		
	2				Glen Bur	nie MD 21061		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	-1-0-		,,,,		
	Registi	ar	OUI 3 U ZUUV PARAMA PR	ADBARI)				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

3. Time of Death

1. Decedent's Name (First, Middle, Last)

1 - For State Registrar

**Physician** 

FERRARI

OCTOBER 26, 2007

Reg. No.-

2 Date of Death 9:00 A.M

4c. County of Death

BALTIMORE

Birthplace (State or Foreign Country)

MARYLAND 10d. Inside City Limits

1 ☐ Yes 2 ☐ XNo

10g. Citizen of What Country? USA

Black, White, etc. Specify: WHITE

16b. Kind of Business/Industry

INSURANCE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

BALTIMORE, MD 21234

20c. Location - City or Town, State

COCKEYSVILLE, MD

TOWSON, MD

LUNG

Approximate Interval Between Onset and Death year

23d. Date of delivery

Year

2 🗆 No 3 ☐ Probably 4 ☐ Unknown

> 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Dev. Year) 10/26/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIGUEL KARACUSCHANSKY M.D.

2005.33d St #640 BACTO ND. 21218

State Registrar

31. Date filed (Month, Day, Year)

OCT3 0 2007

32. R qistrar's Signature

DHMH 17 Rev 1/2001

0

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 27 2007 1:30 A Eleanor Jean Frick Oct. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Timonium Lorien Nursing Ctr. Mays Chapel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days Hours 1□M 2□F Feb. 22,1913 MD 217-09-4572 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Towson Baltimore 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21204 USA 8101 Bellona Ave. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: white ¥☐Widowed 4☐Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 8 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Francis Jarosinski Frances Pavlechi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 600 Straffon Dr. #202, Timonium, MD 21093 Theodore I. Frick/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/30/07 N Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Memorial Gardens Timonium, MD 4☐Donation 5☐Other (Specify) 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. Michael Flagle 10 W. Padonia Rd., Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final years disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): outcome pf pregnancy re birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) egnant at time of death 23e. Did tobacco use contribute to the cause of death? rt I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

other than "natu vent, the Medical

7 is marked othe traumatic event,

permit. Pages 1 and 2 should be filec. Department of Health and Mental Hygin Important: if tiem 27 is marked any injury or other to once.

Funeral Director

Completed by

æ

မ

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

190

g

Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Physician/Medical þ Completed funeral director, Be Certification: To After this To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A

Division or Vital Records, P.O. Box 68760,

FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, 1□Liv 4□Pre 9□Un

Part II.	. Other significant conditions contributing to death but not resulting in the underlying cause (	given in Par

24a. Was	
autor	DSV
perfo	rmed?
1□ Yes	NO
1 1 00	2

Baltono 2004

				performed? 1□ Yes 2√ N	death? lo 1 ☐ Yes 2
			26. Place of Death (C	heck only one)	
1   Inpatient	2 ER/Outpatient	3□ DOA	Other: 4 Nursing Home	5 ☐ Residence	6 ☐Other (Specify)

prior to co	ompletion of cause of
1 ☐ Yes	2 □ No

-/-	
27. Manner of Death	
1 A latural	5 Pending
2 Accident	investigation
3 Suicide	6 ☐ Could not be
4 🗀 Homicide	determined

25. Was case referred to medical

1 ☐ Yes 2 No

4 Homicide

	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo
tion		M	1
t be ed	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fact	lory, office

me of jury		28c. Injury at Work?	
	М	1 ☐ Yes	2 🗆 1

28d.	Describe	how	injury	occurre	ď

29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D	25	65	E

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, OCT 30

nermy/6365 N. Charles Street-Suck 204

State

filled in by the

07-08243			
Andrea	Ferrera		

ndrea Ferrera		State of Maryland / Department of Certificate of			200	7 3470
Physic ledical Exam		1. Decedent's Name (First, Middle,Last)		2. Date of Death Month October 23	No.	3. Time of Death
)		4a. Facility Name (if not institution, give street and number)  Mercy Hospital	4b. City, Town, or Location of Death Baltimore		4c. County of Death	10341115
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.	_	(MM/DD/YYYY) 9. Birth	
Director		213-13-4802 1 M 2 F 47 Yrs.  Usual Residence of Decedent	Months Days Hours Min.	Decemb	Foreign X/15/1956 Cou	ntry) Trenidad
daryland 28a-f show any 1 at once.	for	Naryland Na Bali	en H more			10d. Inside City Limits 1 Yes 2 No
h the Mary 3a or 28a otified at	Ē	512 E. North Avenue	10f. Zip Code 21202	10g	Citizen of What Count	try?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland b and Mental Hygiene. 27 is marked other than "matural", or items 23a or 28a-f shumatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? If Yes 2 No	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ White, etc.	an Indian, Black,
2 hours aft "natural" I Examine	eted by	Lor Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	Yes 2 No specify: t's Usual Occupation (Give kind of woost of working life, DO NOT use retir		Specify: B16  Specify: B16  Martin	lek Pollack
5-0036 fled within 72 Hygiene. I other than the Medical	Comple	17. Father's Name (First, Middle, Last)	ter Parent	/First Middle Ma	Pri	jeet
D 21215 should be filled and Mental Hy 7 is marked o	To Be C	Reynold Billy	Address (Street and Number or F	en 1	Joel	7. 0.1.
<b>-</b> ₽ = = = =		Mr. Warren Roberts 1512	E North	Aveit	Balton 1	MD 21202
MOF Pages nent of nnt: If		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:		30/200	20c. Location - City or 1	icun, MD
Baltimo permit. Pag Department Important: injury or ot		21. Signature of Funeral Service Licensee  Atelle F. Harris T. 1.	are and Address of Facility	AFun	erai Home	PAP. A. 21216
Physician /Medical		Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.      Immediate Cause (Final disease a. Hypertensive Cardiovascular Disease)		réspiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.				
	Examiner	if any, leading to immediate  Cause. Enter Underlying Cause (Disease or injury that initiated				
recuted and ransit		events resulting in death) Last		·		
760, cate be exe physician he burial	Medical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	-
Box 68760 e death certificate b the attending physied for use as the bu	Physician/M	Program at time of doub	al death 3 Ectopic pregnal ner (Specify)	ncy	Month Da	ay Year
P.O. s that the gned by e detach	ğ	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		acco use contribute to the 2 No 3 Probe	
Division of Vital Records, P.O. Is an artending Physician: The law requires that the rate death.  In Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached.	Completed			24a. Was an autopsy perform	prior to co ed? death?	opsy findings available impletion of cause of
# # # W	Be Co	25. Was case referred to medical examiner? Hospital: Innation: 2 FR/Outnationt	26.Place of Death (Check of		No 1 ✓ Yes	2 No
n of Vital Red ling Physician: The  After this certificate funeral director, page	n: To	27. Manner of Death  28b. Time of In		g Home 5 Re 28d. Describe ho	w injury occurred	
rision r Attendi ter death. irector: n by the f	Certification:	2 Accident   Pending   Investigation   28e Place of Injury - At home farm street	1 Yes 2 No	28f. Location (Str.	eet and Number or Rura	al Route Number. City
hou hou y fill		Suicide determined (Specify)		or Town, Star	te)	
To the Ho within 24 To the Fu completely	Medical	Certifying Physician: To the best of my knowledge, death occurred (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	on, in my opinion, death occurred at	due to the cause(: the time, date an	s) and manner as stated d place, and due to the	cause(s)
4	2	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed <i>(Mont</i> October 24, 2007	h, Day,Year)
OCME		30. Name and address of person who completed cause of death (Item 23a)  Mary G. Ripple MD. Deputy Chief Medical Examiner 111	Penn Street, Baltimore, M	D 21201		
St Regis	tate trar	31 Date filed (March Day Vess) 230 Distracts Construe	ule			

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marcella Randall Gayhardt 0320AM 26 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Feb. 7, 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours 1□M 2X F 1909 216-12-2765 Mary land **Director** Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at N/A Baltimore MD 1 ☐ Yes 2 ☐ No 10e. Street and Number 3310 Benson Avenue 10f. Zip Code 10g. Citizen of What Country? 21227 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2XNo If Yes, Give Year or Dates: Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker <u>Own Home</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis J. Randall Catharine Himmel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marcella Hook, daughter 318 A Bar Harbor Rd. Department of Health a Important: If Item 27 Is any injury or other trainonce. Pasadena, MD. 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 □ Cremation 3 □ Removal from State Lorraine Park Cemetery 10-30-07 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup> Name and Address of Facility Ambrose Funeral Home, Ir 1328 Sulphur Spring Rd. 21. Signature of Funeral Service Licensee Inc repe 21227 Arbutus, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to Examiner MARCELLA Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? vision or Vital Records, Be Completed by 1 ☐ Yes 2XNo 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autopsy 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 0 Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2. 29c. License number 29b. Signature and title of

State Registrar

AMARINDER

31. Date filed (Month, Day, Year)

3 0

Ave, Baltimore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANDHU

32. Registrar's Signature

07-08273 Emmi Grelli

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.										
Physician/	<b>/</b> 1	1. Decedent's Name (First, Middle,Last)  2. Date of Death								me of Death 338 hrs		
edical Examine		Emmi E. Gr					October 2			336 1115		
	4	a. Facility Name (if not institution Good Samaritan Hosp	4b. City, Town, or Location of Death Baltimore					4c. County of Death $n/a$				
Funeral Director		5. Social Security Number	6. Sex 7.	Age (In yrs. last birl	thday) Yrs.	If Under 1 Year Months Day				th(MM/DD/YYYY 28 1925	Foreign	Germany
be filed within 72 hours after death with the Maryland mall Hygiera mail Hygiera than "matural", or items 23a or 28a-f show any vent, the Medical Examiner must be notified at once.	10 be completed by runeral birector	Jaual Residence of Decedent  10a. State 10b. County 10c. Street and Number 10c. Street and	n Ave.  12. Was Decected Armed Force 1 Yes, Give Year cord only highest grade  College (1-4 n/a, Last)  Saumler  Ship (Type, Print)  Celli/son  Removal from pecify:	10c. City, Town Ba1  tent Ever in U.S. ses? 2 X No  completed) 16a. or 5+) 15	or Location timor  13. Was If Ye  1 Decedent during mo  Ho  28.02 of Dispositatory or oth ley Va	Decedent of His, specify Cuba  Yes 2 <sub>X</sub> No s Usual Occupa st of working life  Dememake:  Address (Stree  Willow  Lion (Name of coer place) alley Mo	spanic Origin, Mexican, Specify: tion (Give k. DO NOT u  18.Mother's Eliza et and Numi View metery, emoria	n? (Spece Puerto Ri ind of woo use retired to be the ber or Ru Ct., 10/2	cify Yes or Nican, etc.)  rk done d)  First, Middle,  (unk) ral Route Nu Hamp: Date 29/07	10g. Citizen of W  14. Race Whit  Specify:  16b. Kind of Be  Own  Maiden Surname  nown by mber, City or Too  stead, M  20c. Location  Timon	hat Country?  USA  - American le, etc.  Home  inform wn, State, Zip  - City or Tow  ium, M	Inside City Limits Yes 2 No Indian, Black,  white stry  ant) Code)  44  m, State
Physician /Medical Examiner		Bryan W. Clary  Lemmon Funeral Home of Dulaney Valley, Inc.  10 W. Padonia Rd., Timonium, MD 21093  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Approximate Interval Between Onset and Death  Death										
tox 68760, ceah certificate be executed e attending physician and for use as the burial - transit	edical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a cons										Year
ords, P.O. B we requires that the de as been signed by the	≥ા	Part II. Other significant condi	a Olikilot		1 Ye 24a. Was auto							
tal Recition: The la	္မွ	25. Was case referred to medic	al			26.Pla	e of Death	(Check o				
Vita ysicia his cer	Ö	examiner? 1 ✓ Yes 2 No	Heenitel.	npatient 2 🗸 ER/	Outpatient	3 DOA	Other <sub>4</sub>	Nursing	Home 5	Residence 6	Other:	
on of Viending Physicath.	⊢ ի	27. Manner of Death  1 Natural 5 Per	28a. Date of (Month) Oct 24, 2		o. Time of I 00 hrs		ury at Work	. !	28d. Describ Subject fe	e how injury occu 	urred	
Division pital or Atten ours after death neral Director: filled in by the	Certification:	2 Accident Inv. 3 Suicide 6 Condet 4 Homicide	building, et		28f. Location (Street and Number or Rural Route Number, City or Town, State) 5921 Seflon Avenue, Baltimore, MD							
To the Hospi within 24 hou To the Funer completely fi	Medical C	29a. Certifier 1 Certifying I	Physician: To the best aminer: On the basis o and manner st	f examination and/o	death occur or investiga	red at the time, tion, in my opini	date and pla on, death oc	ace, and ccurred at	due to the ca	use(s) and mann te and place, and	ner as stated.	ause(s)
7. wii.	Be	29b. Signature and title of certif	Aleu.		29c. License number O.C.M.E.					29d. Date signed (Month, Day, Year) October 25, 2007		
12		30. Name and address of person Zabiullah Ali, M.D.	on who completed caus Assistant Medic			nn Street, Ba	altimore,	MD 212	201			
	ate	31. Date filed (Month, Day, Year		gistrar's Signature								
Registr		OCT 3 (	No.	gree B	Lange							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla		artment of H ertificate of I			giene Reg. No.2	107	34712		
ig.	Dhusiai		1. Decedent's Name (First, Middle, Last)		2. Date of De Month	ath Day	Year	3. Time of Death					
	Physicia /Medic		Lillian M. Haake						ctober 27, 2007   12:3				
j	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Dea	ath	4c. County of Death				
	Forest		Charlestown Care 5. Social Security Number 6. Security Number					rs. 8. Date of Bir	Ba1	Nace (State or Foreign ntry)			
	Funeral Director			<sup>™ 2</sup> XF 94	Yrs.	Months Days	Hours Mir	n. (Month, Da Dec . 29	y, Ye <i>ar)</i> • 1912	912 New Jersey			
	pu ,		Usual Residence of Decedent	100 (	City, Town or L	ocation					0d. Inside City Limits		
	arylar show	7	10a. State 10b. County						'	1 ☐ Yes 2 ☐XNo			
	the M 28a-f potifie	Directo	Maryland Baltimore	3 (	Catonsv	111e 10f. Zip Code			10g. Citizen o	of What Cour			
	3a or		707 Maiden Choice	Lane		21228			USA		.,		
	death ms 2 r mus	by Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Origin?	(Specify Yes or No		ace - Americ			
Maryland 21215-0036 d 2 should be filed within 72 hours after th and Mental Hygiene. ?? is marked other than "natural", or Ite	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 □ Never Married 2 □ Mamed 3 🏿 Widowed 4 □ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:			Specify:	erto nicari, etc.)	1	city: Whi			
20	72 hc 'natu	Completed	15. Decedent's Edu (Specify only highest grad	e completed)   (Giv		edent's Usual Occup e kind of work done	durina most of w	orking	16b. Kind of	b. Kind of Business/Industry			
7	vithin ane. than '	dm	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired omemaker	<b>3</b> )		Own H	II			
9	filed v Hygie other i	ပိ	17. Father's Name (First, Middle, Last)	3.		Ollemaker	18. Mother's N	ame (First, Middle					
aŭ	ld be ental ked o ic eve	To Be	William James McKe	enna			Mayme	Enright	right				
ary	shou and M s mar umat	۲	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mai	ling Address (Street	and Number or	Rural Route Numb	er, City or Tow	ın, State, Ziç	Code)		
Σ	and 2 salth n 27 i		Robert G. Thelen			Oak Court							
altimore,	ges 1 t of H if iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	20b. Removal from State	. Place of Disp cemetery, cr	oosition (Name of ematory or other place		Date	20c. Location	•			
≣	t. Pa rtmen rtant: njury		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)					/30/2007					
Bal	permi Depar Impor any ir		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228										
Г			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the de ne cause on each line.		4	ng, such as card	liac or respiratory a	arrest,		Approximate Interval Between Onset and Death		
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	)e men	tia							
	Examiner			Due to (or as a conse									
	10.77	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b									
	cuted id ransit	Examiner	that initiated events	C									
Ö,	e exection and an arrial-tr	Ex	resulting in death) Last	Due to (or as a conse	equence of):								
68760,	ficate be executed physician and s the burial-transit	edical		d									
	ding p	/Me	IF FEMALE:	23c. If yes, outcome pf preg	nancv			224 [	Data of dalin	of delivery			
Box	atten for u	Physician/M	in the past 12 months?	1 Live birth 2 ☐ Fe 4 Pregnant at time o	у		1	23d. Date of delivery  Month Day Year					
Р. О.	the day the ached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of death 5☐ Other (specify) 9☐Unknown									
Vital Records, P	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions co	ntributing to death but not re	esulting in the	underlying cause giv	en in Part I.			acco use contribute to the cause of death?  2 □ No 3 □ Probably 4 Æ Unknown			
S	w requir	letec			24a. Was	24a. Was an autopsy findings avail prior to completion of cause death?							
æ	The lare has	Completed			<ul><li>auto perf</li></ul>								
ita		Be C	25. Was case referred to medical	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Plage of Death (Check only one)									
<u>ř</u>	Atter ding Physician: The law rdeah. ector. After this certificate has by the funeral director, page 2 s	To B	examiner? 1 ☐ Yes 2 ☐ ₩6	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
0	ding Pi h. After ti funeral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28d. Describe how injury occurred								
Sio	tter di leath. tor. A	cati	2 Accident investigation 3 Suicide 6 Could not be	One Plane of initial At	205 Leasting (Street and Number on Dural Doute Number								
Division or	al or Al	Certification:	4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spe	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	To the Hospital or Attending Phwithin 24 hours a ler death.  To the Funeral Director. After th completely filled in by the funeral	Medical C		sician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  / and manner stated.									
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Da									
	5		1/1	ND		D7.	DAJAAJ			16 mayle			
/	0		30. Name and address of person who c	completed cause of death (It	1	e, Print)	Cato	Nivila	Man	(c,			
ı	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig		49		-	V -				
	Regist		OCT 3 0 2	667	1 6	and o							

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Month **Physician** Oct. 27, 5:15 a<sup>M</sup> D. HALE SAMUEL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore 1411 South Carey Street if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1**⊠** M 2□ F 72 Sept.22, 1935 Virginia Director 229-38-4259 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event. the Medical Examination. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits N/A Baltimore 1 Yes 2 No Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1411 Carey Street 21230 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify.White 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pipefitter Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Hale Margaret Barteel ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Hale (Daughter) 423 Cedar Hill Road, Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 10-30-07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A. Fort Avenue, Baltimore, Maryland 21230 23a. P. 11. Enter the disease, or complications that caused the clock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 5 ☐ Other (specify) ned by the a 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 es 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 TYes 2 110 To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P 1 Inpatient After this 28a. Date of Injury (Month, Day the funeral 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier se of death (Item 23a) (Type, Print) Harbor Mingry Cale Q Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** <u>4:4</u>0a<sup>™</sup> John Honeycutt Oct. 26 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ivy Hall Nursing Center Middle River er 1 Year | If Under 24 Hrs. | <u>Baltimore</u> Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** Months Days Feb. 18, Hours 1 X M 2 □ F 95 NC 238-26-2149 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State "naturai", or items 23a or 28a-f show edicai Examiner must be notified at MD Baltimore Middle River 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? 14 Yewmeter Drive 21220 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No White Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene.
Int: If item 27 is marked other than Inty or other traumatic event, the Electrician Westinghouse 4th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arron Honeycutt Martha Frye ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy McNeal /daughter <u> 1200 Cord Street Baltimore MD 21220</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Cemetery 10/29/07 Baltimore MD 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o important: If any Injury or 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final emen tra **Physician** disease or conditi resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending phase as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 9∏Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 2 No 3 Probably 4 Unknown 1 ☐ Yes been signated by Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has l certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? After this certific funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury within 24 hours after uses.... To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier , MD D0061907 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) State Registrar

hukwuma 32. Registrar's Signature

Mace Avenue, Bultimore MD 21221

Physicia /Medica Examine

**Funeral** Director

	Please <sup>-</sup>	Type or Prin						_		_	le.			
	1 - For State Registrar	State of Ma	-		tment of F ificate of		and Me		giene Reg. Na	200	7	34	715	
an cal	1. Decedent's Name (First, Middle, Last Lillian Hend						2. Date of Dea 10 <sup>th</sup> 25	۳7 <sup>۲</sup>	/ear	3. Time 6:11	of Death  P M			
er	4a. Facility Name (If not institution, give 1421 Maryland Ave	4b. City, Town, or Location of Death Severn					4c. County of De							
	236-12-9272	ex 7. Age □ M 2 x 92		If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.			B. Date of Birt (Month, Day Jan。 2	9. Birthplace (State or Formula) Pennsylvan						
'n	Usual Residence of Decedent  10a. State 10b. County Anne Art	undel	or Loca	ition		10d. Inside City Limits 1  ☐ Yes 2 No								
al Direct	19e, Street and Number 1421 Maryland Ave		10f. Zlp Code 21144					10g. Ci	nat Cou	intry?				
Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Forces?	l ☐ Yes 2 ♣ No f Yes, Give			Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 No Specify:					D. Race - American Indian, Black, White, etc. Specify: White			
pleted	15. Decedent's Ed (Specify only highest grad		16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)				t of working	/king 16b. Kind of Bu				usiness/Industry		
e Con	17. Father's Name (First, Middle, Last)		Secretary Drug Sto							re				
To B	Harry W. Lines		Nora Agnes Wertz											
	19a. Informant's Name/Relationship (Type. Print)  Laura Lewis, granddaughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1421 Maryland Ave. Severn, MD. 21144													
	20a. Method of Disposition  The Buria! 2 Cremation 3 4 Donation 5 Other (Specify,	cemeter	Place of Disposition (Name of cemetery, crematory or other place) t Lincoln Cemetery 10-29-0					20c. Location - City or Town, State Washington DC						
	21. Signature of Funeral Service Licensee  Ambrose Funeral Home, Inc.  1328 Sulphur Spring Rd. Arbutus, MD. 21227													
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only c Immediate Cause (Final disease or condition resulting in death)	a. Adu	tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval							Approxim Interval E Onset an	nate Between			
J.	Sequentially list conditions, if any, leading to immediate	b												
xaminer	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C												
_	L	d.												
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	pf pregnancy 2 ☐ Fetal death time of death	death 3 Ectopic pregnancy					23d. Date of delivery  Month Day Year						
ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  12 Yes 2 No 3 Probably 4 Unknown													
Complet			24a. Wa aut peri 1 Yes					utopsy prior to completion of cause of death?						
Be	25. Was case referred to medical examiner?  1													
n: To	27. Manner of Death	1 ☐ Inpatie	ry 28b. T		3 □ DOA □ UII 28c. Inju Woi		ursing Hom	Bd. Describe				ify)		
Medical Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	1 M 1				Yes 2 No				et and Number or Rural Route Number, State)				
dical Co	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best on the basis of and manner sta	examination and	death of	occurred at the tiestigation, in my	me, date ar opinion, dea	nd place, a ath occurre	nd due to the d at the time,	cause( date a	s) and man nd place, ar	ner as nd due	stated. to the caus	e(s)	
Me	29b. Signature and title of certifler				29c. Licens	se number			29d D	ate signed	(Month	Day Year	-}	

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

SRIDHAR. ATIURI, 8109 Richie A

29c. License number
D 50470 21122

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Items 5, 15, 20a, b.c. per fh. 8872, 10/30/07dhb.

1- For Amend Item 25 per me, g872, 10/23/07dhb of Health and Mental Hygien 7

Reg. No.

Reg. No. 34716 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 10.15 AM JUNE 2007 LURETHA HARLEE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday)
Yrs. Wonths Days Hours Min.

1917

1917

1917 GOOD SAMARITAN HOSPITAL 5. Social Security NumberUnk Birthplace (State or Foreign Country) 1□M 20 F Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo MD BALTIMORE 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 1200 LINDEN LEAF CT. Funeral 21202 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 🛛 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th SEAMSTRESS **FACTORY** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ARCHIE BELTON HARLEE ANNIE JANE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES McCALL/SON 1200 LINDEN LEAF CT., BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sacred Heart 06/11/2007 Dundalk, MD 21. Signature of Fune I Service Licensee 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 23a. Part f. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure just only one cause on each line.

Immediate Cause (Final 2007-09 EASTERN AVE., BALTIMORE, MD Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death PERSISTANT NEGETATIVE STATE Due to (or as a consequence of): ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): DRUG RESISTANT PNEUM resulting in death) Last Due to (or as a consequence of): Physician/Medical Sepsis CERT IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA, RENAL FAILURE 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown DECUBITUS ULLERS 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 1 XYes 25 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending

Examiner Vital Records, P.O. Box 68760 After this certification funeral director. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

**Funeral** 

Director

or 28a-1 ahow

23a

Baltimore, Maryland 21215-0036

Pages 1 end 2 should be filed within nent of Health and Mental Hygiene. int: if itam 27 ia marked other than

permit. Page Department of Important: if any injury or pnce.

**Physician** 

/Medical

Certification: To

Medical

29a. Certifier

2 Accident 3 Suicide

(Chack only one)

6 Could not be 4 - Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

investigation

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 ☐ Yes 2 ☐ No

DO064047

29d. Date signed (Month, Day, Year) 2ND, 2007 JUNE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
STUTI SHANKAR 5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239

STUTI SHANKAR

State Registrar

31. Date filed (Month, Day, Year) 2 3 2007 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Francis H. Huber,		S - For State	state of Maryla		rtment of <i>tificate of</i>		nd Mental		eg. No. 2	007	3471
Physician		egistrar 1. Decedent's Name (First, Mid	dle,Last)					2. Date of Dea	th	3.	Time of Death
Medical Examin	er	Francis H	Henry Hub		r.			Month October 2	7, 2007		1859 hrs
		4a. Facility Name (if not institut		mber)	1	4b. City, Town, o		eath	4c. County	re County	y
	۹.	Northwest Hospital C		7. Age (In yrs. la	st birthday)	If Under 1 Ye		4Hrs. 8. Date of Bir	th(MM/DD/YYY)	y) 9. Birthpl	
Funeral Director		216-40-1873	1 X M 2 F	65	Yrs	Months Da		Min. 7/15/		Foreign	ry) MD
Direction.	ŀ	Usual Residence of Decedent	121 M 2 F			"					
any	Ì	10a. State 10b. Count	•	10c. City,	Town or Locat						od. Inside City Limits
nd show	اڃ	MD Balt	timore		Reist	erstown					Yes 2 XX No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 27 Shropshi	re Court			10f. Zip Code 211	.36		I0g. Citizen of W	hat Country/ USA	
rith the		11. Marital Status		cedent Ever in U.				? ( Specify Yes or No			n Indian, Black,
eath w	Funeral		Married Armed Fo	orces?	If Y	Yes, specify Cub	an, Mexican, P	uerto Rican, etc.)	Whit	te, etc.	nite
after d	g F		Divorced If Yes, Give Yea	ar		Yes 2 X			Specify:		
natur:		15. Decedent's Education (Sp			16a. Deceder during n	nt's Usual Occup nost of working li	ation (Give kin fe. DO NOT us	d of work done e retired)	16b. Kind of B	usiness/ind	ustry
36 in 72 h	let let	Elementary/Secondary (0-1:	2) College (1	1-4 or 5+)	M	echanic			Auton	notive	٤
-003 l withi giene.	Completed	17. Father's Name (First, Midd	lle, Last)			0011011111	18.Mother's	Name (First, Middle,	Maiden Surnam	e)	
e filed tal Hy ked of	Be C			ber Sr.				Elizabet			
212 ould b I Ment is mark	2	19a. Informant's Name/Relation			19b. Mailir			er or Rural Route Nu			(ip Code)
MD d 2 sho lth and n 27 is		Mrs Mary Nage	1 / sister					Bridgewi	11e DE 1		own State
re, s I and f Heal If iten	- 1	20a. Method of Disposition  1 Burial 2 X Cremat	ion 3 Removal f	rom Stata	crematory or o	esition (Name of other place)		11/1/2007		•	
imo Page nent o ant: or oth		4 Donation 5 Other	Specify:	Che	-	e Crema					
Salti ermit. epartr mport		21. Signatur of Fun rat Servi	ce Ligensee	M01364	22.	2nd Ave	ess of Facility of	Singleton n Burnie	Funeral	. & Cr	emation Srvc
	_	23a. Part I. Enter the disease,	or complications that								Approximate Interval
Physician Madical		failure. List only one cau	use on each line.							-	Between Onset and Death
xaminer		Immediate Cause (Final disea or condition resulting in death		a consequence of		alo va o o a la la					
		Sequentially list conditions,	b								
	aminer	if any, leading to immediate cause. Enter Underlying Cau		a consequence o	of):						-
11	kam	(Disease or injury that initiate events resulting in death) La:		a consequence c	of):						
executed an and all - transi	al Ex		d								
to, ebe executed ysician and burial - transit	edical	UNPENDED	AMENDED						Lood Data	of delivery	
760 ficate g phys	/Me	IF FEMALE: 23b. Was decedent pregnant i		, outcome of preg		Fetal death	3 Ectopic	pregnancy	23d. Date Month		ay Year
Sox 6876( leath certificate e attending physical for use as the b	sician/M	past 12 months?	4 Preg	nant at time of de		Other (Specify)					
Records, P.O. Box 68760. The law requires that the death certificate care has been signed by the attending phypage 2 should be detached for use as the b	Physi		Unknown g Unkr				Estanta Des	1 23a Dic	I tobacco use cor	ntribute to ti	he cause of death?
P.O.	by P	Part II. Other significant cor	iditions contributing	to death but not i	resulting in the	e underlying cau	se given in Pari			3 ✔ Proba	
Vital Records, P.O. Be ysician: The law requires that the de his certificate has been signed by the direction, page 2 should be detached if	edt							24a, Wa	as an   24b	. Were aut	opsy findings available
ord tw req as bee 2 shou	Completed							aut	opsy formed?	prior to co death?	ompletion of cause of
Rec The la cate h	Som							1 V Ye	s 2 No	1 V Yes	s 2 No
tal P cian: certifi ector,	Be (	25. Was case referred to med examiner?	Hospital:		50/0 1		Tour	Check only one)  Nursing Home 5	Residence 6	6 Other:	
Division of Vital Records, rat or Attending Physician: The law require is after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be in by the funeral director, page 2 should be also be a should be also	ဥ	1 ✓ Yes 2 No 27. Manner of Death		Inpatient 2	28b. Time c		Injury at Work?		e how injury occ		
n of \ ding Phy h. : After the	ion:	1 of Noticel	(Mon	nth, Day, Year)			Yes 2	No			
Sional Attentrated by the	icati	2 Accident	nvestigation 28e Pia	ace of Injury - At I	home, farm, st	reet, factory, offi	ce building, etc	28f. Location	n (Street and Nu	mber or Rur	ral Route Number, City
Divi	Certification:		Could not be determined (Specify					or Towr	n, State)		
Division  Hospital or Attend 24 hours after death. Funeral Director:		29a. Certifier	g Physician: To the b	est of my knowle	dge, death occ	curred at the time	e, date and place	ce, and due to the ca	ause(s) and man	ner as state	ed.
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical	Examiner: On the basis	s of examination stated.	and/or investig			curred at the time, da			
E 3 E 8	Me	29b. Signature and title of ce	rtifier				ense number				nth, Day, Year) 7
		Mhner Bu	and M	$\geq$		0	.C.M.E.		October	28, 2007	
		30. Name and address of per				Penn Stree	t Baltimore	MD 21201			
le		Melissa Brassell, M		ledical Exam Registrar's Signa							
Si Regis	tate tra:		2007	registral's Signa	J. 190	evel!					

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F		-	giene (	07	34718
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Ica B. Himme	1				2. Date of De Month Octobe	r 24, 2	20 <b>07</b>	3. Time of Death 11:00 A M
	Examin		4a. Facility Name (If not institution, give s Stella Maris Hospic			4b. City, Town, o	ium			nty of Death	County
	Funeral Director		207 20 3201	M <del>XX</del> F 7. Ag	e (In yrs. last birthday 81 Yrs.	Months Days	If Under 24 H Hours M		ıy, Year)	Coui	place (State or Foreign ntry) hio
	a-f show	ctor	Usual Residence of Decedent  10a. State  10b. County  Maryland  N/A		10c. City, Town or L	ocation Baltimon	re			1	10d. Inside City Limits
	n with the	al Director	10e. Street and Number 1304 Weldon Aver	nue		10f. Zip Code	2121	11	10g. Citizen o	of What Cour	usa
020	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. And T is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	2. Was Decedent Armed Forces? 1 Yes XXII If Yes, Give Year or Dates:	Ever in U.S. 13	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2XXNo	fispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	Spec	ace - Americ lack, White, cify: W	
0000-01717	within 72 ho lene. than "natur th Medical"	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	during most of v	vorking	16b. Kind of		•
מומ ע	ould be filed w Mental Hygie arked other t atic event, th	To Be Co	17. Father's Name (First, Middle, Last) Otis Miller	Nurse    Hospital-Helper's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Surname)						altncare	
Ě	1 and 2 should I Health and Men em 27 Is marker ither traumatic (		19a. Informant's Name/Relationship (Type Patricia Haller	e. Print) Daught				Rural Route Numb		vn, State, Zip 21211	Code)
(I)	Pages 1 al lent of Hea nt; If Item ry or othe		20a. Method of Disposition  ★☆Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State		oosition (Name of ematory or other pla		Date 10/29/07	20c. Location Baltin	•	own, State Maryland
Dall	permit. Pages: Department of H Important; If Ite any injury or of once.		21. Signature of uneral Service treense	e l	1	22. Name and Addre Burgee-He 3631 Fall	ess of Facility enss–Sei	itz Funer	al Home	e, Inc	•21211
	Physician /Medical Examiner  the prival-transit	Jical Examiner	23a. Part1. Enter the dise se, or con plis shock, or hear failure. List any on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of): a consequence of):						Inierval Between Onset and Death
P.O. Box 68	ath certific attending pl	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 N No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		1	Date of deliv Month	rery Day Year
ds, P	uires that the de signed by the a Id be detached	þ	Part II. Other significant conditions con	tributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.		tobacco use co Yes 2 ☐ No		the cause of death? bably 4 <b>∏</b> Unknown
	The law requir cate has been si page 2 should I	Completed						24a. Was auto perf 1∐ Yes	psy ormed?	b. Were auto prior to co death? 1 \( \sum Yes	opsy findings available mpletion of cause of
or VII	iding Physician: Th th. : After this certificate i funeral director, pag	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No	ospital: 1	ent 2 ER/Outpati	ent 3 DOA Oth		Death <i>(Check only</i> g Home 5 ☐ Res		Other (Speci	fy) HOSPICE
JIVISION	or Atter after deat Director in by the	Certification:	27. Manner of Death  1  N Natural 2	28a. Date of Inju (Month, Da 28e. Place of inj building, et		M 1□	Yes 2 No				al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in by	Medical C			of my knowledge, de of examination and/or ated.						
)	To the within 2 To the comple	Me	29b. Signature and title of certifier	-		29c. Licen:	se number	<i></i>	29d. Date sig	ned (Month)	
	Sta	ate	30. Name and address of person who co DR • TARIQ MAHMOOD 31. Date filed (Month, Day, Year)	2300 D	leath (Item 23a) (Type ULANEY VAI rar's Signature		TIMONIU	M, MD 210			

OCTOBER 24, 2007

ICA HIMMEL

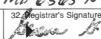
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** OCTOBER 25 РМ RITA HFI FN **HERBST** 2007 3:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year | Min. | 06/25/1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 □ M 2 😱 80 219-22-4502 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be it 14. Race - American I Black, White, etc. Funeral 2133 WOODBOX LANE APT. 21209 American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No WHITE Saltimore, Maryland 21215-0036 Specify Specify: Completed by 3 

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) filed withi Hygiene. ACCOUNTANT U.S. GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F Be **COOPERSTEIN** SARAH RUBINSTEIN **EMANUEL** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If Item 27 is u 9 SHAFTSBURY COURT - REISTERSTOWN, MD 21136 MICHELE TRIEB / DAUGHTER 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition ARITHGTON CHIZUR 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10/28/2007 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEPATORENAL SYNDROME WEEKS /Medical Due to (or as a consequence of) Examiner Hypovolemic SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit be executed Gue to (or as a consequence of) ASTRO INTESTINAL HUJUST 31, 2007 P.O. Box 68760. physician Physician/Medical POLYCY THEMIA the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ANo Month Year Dav 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 PORTAL VEIN THROMBOSIS 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 ☐ Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To SIL funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t after death. 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Hospital the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D 64395 OCTOBER 25, 2007 ess of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBERMAN, MD 6565 N CHARLES ST. SUITE 209 BALTIMORE, MD 21204

State Registrar 31. Date filed (Month, Day, Year) OCT3 0 2007



### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** OCTOBER Marie Iglehart 22 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE AGNES SAINT If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🙀 F Mar 1, Director Maryland 216-28-5907 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1√2Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 S. Athol Avenue 21229 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: white Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 11 housekeeper residentials 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Cramblitt William Hinegardner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Iglehart/son 3924 McDowell Lane Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State of Funeral Service Vicensee Ronald S. Wade <sup>22.</sup> Name and Address of Facility Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part1. Exter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, othean failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BRAIN ERNIATION /Medical Due to (or as a consequence of): Examiner PNEUMONIA MRSA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner law requires that the death certificate be executed the attending physician and ched for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Linknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1☐ Yes Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient Certification: To 1 ☐ Yes 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident completely filled in by the 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P 20998 tichny Degrika OCTOBER 23, 2007

DHMH 17 Rev 1/2001

State Registrar

A

GLE

900 S. CATON AVE, BALTIMORE, MD - 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

VISHNU DEEPIKA EVURT,

31. Date filed (Month, Day, Year)
OCT 3 0 2007

07-0 Bee ck Indelible Ink. Ensure All Copies Are Legible.

08209		Please Type	e or Print in t te of Marylan	d / Denar	tment of	ık. ⊑ris Health	and	Menta	l Hygie	ene	9.2.0.	•	0.7	0170
echer Jacobs	1-1	State For State	te or marylan	Cert	ificate of	Death				R	eg. No.	20	07	
Physician		gistrar Decedent's Name (First, Middle	,Last)						2. D	ate of Dea	th Day	Year		e of Death 02 hrs
*! Examine	гΒ	eecher Allen Ja	acobs, Sr.							onth ctober 2	1, 2007	County of Deat		
	48	a. Facility Name (if not institution	, give street and numb	per)	4	b. City, Tow Baltimp		cation of	Death		170. 0	ocinty of Door		
		University Hospital		Age (In yrs. la	et hirthday)	If Under		If Under	24Hrs. 8.	Date of Bi	rth (MM/DI	D/YYYY) g. B	irthplace	(State or
Funeral		Social Security Hamber		55		Months	Days	Hours		Jan.			ign (ountry)	1
Director			1 X M 2 F		Yrs									
à:	_	sual Residence of Decedent  0a. State 10b. County		10c. City,	Town or Locat	ion								nside City Limits
1 10w 21	М	D N/A		Bal	timore									Yes 2 No
ne Maryland or 28a-f show any fied at once.	0 1	0e. Street and Number				10f. Zip C					10g. Citize	en of What Co	untry?	
he Ma		311 Kuper Stre	et			2122								Es Dissi
with t		1. Marital Status	12. Was Dece	dent Ever in U.	S. 13. Wa	s Decedent	of Hisp Cuban,	anic Origi Mexican,	n? ( Specif Puerto Ric	fy Yes or N an, etc.)		<ol> <li>Race - Am White, etc.</li> </ol>		dian, Black,
death	Funeral	1 Never Married 2 Ma	1 Yes	2 X No		Yes 2X	_				,	<sub>Specify:</sub> whi	te	
after	<u> </u>	Widowed 4 Divide 15. Decedent's Education (Special Control of the	orced If Yes, Give Year or Dates:	completed)	16a. Deceder	nt's Usual O	ccunatio	n (Give k	ind of work	done		ind of Busines		у
hours	e –		College (1-		during n	nost of worki	ing life. I	DO NOT L	use retired)	)	ш	ealth (	`nro	
36 nin 72 e. than '	e l	Elementary/Secondary (0-12)			Delive	ery							Jare	
d with	Completed	17. Father's Name (First, Middle,	Last)							irst, Middle	, Maiden	Surname)		
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than in event, the Medica	ည္က E	Beecher Yates			1405 14-115	- Addross	(Street	Jady	rs Jac	CODS al Route N	umber, Ci	ty or Town, St	ate, Zip (	Code)
21 hould nd Me is ma		19a. Informant's Name/Relations				Kuper					MD :	21223		
5re, MD 21215-0036 ss I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at once.		Sandra L. Jacob 20a, Method of Disposition	S/WILE	20b.	Place of Dispo	sition (Nam	e of cen	netery,		Date	20c. l	Location - City		
imore, Pages 1 a ment of He tant: If ite		1 X Burial 2 Cremation	n 3 Removal fro	om State Me	crematory or d	ther place)	POF	ial	10-2	5-200	7 E1	kridge	, Mai	ryland
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	η,	4 Donation 5 Other S 21. Signature of Funeral Service	pecify:	6	22	Name and	Address	of Facility	AUTOL	ose I	uner	al Home	0	ns own
Baltimore permit. Pages 1 Department of F Important: If i	- U	120/10	a_		2	719 Ha	ammo	nds I	Terry	Rd.	Lanse	downe l		
Physician	+	2 a. Part I. Enter the disease, or failure. List only one cause	r complications that ca	aused the deat	h. Do not enter	the mode o	f dying,	such as c	ardiac or r	espiratory	arrest, sho	ock, or heart		proximate Interval etween Onset and Death
Medical		Immediate Cause (Final disease	<sub>a.</sub> Hypertensiv			diovascul	lar Dis	ease					_	Death
∠xaminer	1	or condition resulting in death)	Due to (or as a	consequence	of):									
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	consequence	of):									
	ij	cause. Enter Underlying Cause (Disease or injury that initiated	U		of):								_	
₩ 5 . E	Examiner	events resulting in death) Last	Due to (or as a d.	consequence	oi).									
executed an and al - transit	g	UNPENDED	AMENDED											
ox 68760, eath certificate be e: attending physiciar for use as the burial		IF FEMALE:	23c. If yes,	outcome of pre	egnancy						23	3d. Date of de	livery Day	Year
387 rtifica ling ph	sician/Med	23b. Was decedent pregnant in past 12 months?		oirth nant at time of	2	Fetal death	3	Ectop	ic pregnan	icy		Month	Day	· car
OX (eath ce attend for use	sici	1 Yes 2 No 9 U	nknown g Unkn		death 5	Other (Spe	Ciry)							
D. B. It the de ached a	Phy	Part II. Other significant cond	litions contributing t	o death but no	t resulting in th	e underlying	g cause	given in F	Part I.					cause of death? y 4  Unknown
, P.O. ires that th signed by	l by	Diabetes mellitus												sy findings available
ords, w requires ts been s should t	etec				_					a	Vas an utopsy	pric		pletion of cause of
e law e has ge 2 sh	Completed by										erformed' 'es 2		Yes	2 No
tal Rec		25. Was case referred to medi	cal				26.Plac	-	h (Check c					
Vita ysicia his cer direct	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1		✔ ER/Outpati		DOA	Other <sub>4</sub>		g Home 5		njury occurred	Other:	
of Viving Physical After this	n: T	27. Manner of Death	28a. Date (Mont	e of Injury th, Day,Year)	28b. Time	of Injury		ury at Wo	_	Zou. Desc	inge now i	injury occurred	1	
ion rtendi leath. tor: /	atio		ending vestigation	ace of Injury - A	Abomo form (	street factor				28f. Locat	ion (Stree	t and Number	or Rural	Route Number, City
ivis or At after of Direc	Certification:		ould not be 28e. Pla etermined (Specify		a nome, iaim, s	5(1661, 146101	y, 011100	, , , , , , , , , , , , , , , , , , , ,		or To	wn, State)			
Division of Vital Records, P.O. Box 68760, To the Itospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		4 Homicide	1 1 1 1 1		ledge, death o	ccurred at th	ne time,	date and	place, and	due to the	cause(s)	and manner a	s stated.	
the Ho in 24 the Fu pletel	Medical	(Check only one) 2 Medical E	xaminer:On the basis	s of examination	n and/or inves	tigation, in n	ny opini	on, death	occurred a	it the time,	date and	p.a.o., a		
To 1	Med	29b. Signature and title of cer	and manner	state <u>u</u> .			9c. Lice	nse numb			29	d. Date signe	d (Month	n, Day, Year)
		Lanha	Dea 1	nin			0.0	C.M.E.			0	ctober 22,	2007	
1		30. Name and address of pers		use of death (I	Item 23a)		01	4 D=111	ang 8.41	0.24204				
5		Tasha Greenberg N		Medical Ex		11 Penn	Stree	i, Baitin	ible, Mi					
	tate	DOT II	0 2007 32.	Registrar's Sig	nature	souls.	No.							
Regis	316	UUI	O LOUI	Bar Albert										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26 perPHYS C872 10/30/07 WS
State of Maryland Department of Health and Mental Hygiene

			1 - For State Registrar				•			Death			Reg. No.	201	07	34	722
*	Physicia	an	Decedent's Name (First	Middle, Last)							2	2. Date of Do Month	Day		Year		e of Death
	/Medic		Monica			L.				ress		10	18		007	5:3	30p. <sup>M</sup>
1	Examin	er	4a. Facility Name (If not in	stitution, give s	street and number	)		4b. City	, Town, or	r Location	of Death		4c.	County	of Death		
			4912 Chalo	rove	Ave				Balt	imor	e.						
	Funeral		<ol><li>Social Security Number</li></ol>	6. Sex	7. A	ige (In yrs.	last birthday)		er 1 Year	If Under Hours	Min.	B. Date of Bi (Month, D	rth av. Year)		9. Birth	place (Sta	te or Foreign
	Director		213-60-109	4	JM ZLX	72	Yrs.	I III I	Dayo	110010				34		nica	
	D		Usual Residence of Deced	lent													
	ylar how at		10a. State 10b.	County		10c. Cit	y, Town or Lo	cation									City Limits
	Mai F-f sl	호	MD	NA			Balt	imo	ro							1 🛛	'es 2 □ No
	282 noti	Director	10e. Street and Number			1			ip Code				10g. Citi	zen of V	Vhat Cou	ntry?	
	Mitthe Sa on the		4010 05-3-						0.7	07.5							
	eath	era	4912 Chalo	rove	AVE  12 Was Deceden	t Ever in II	S 13 1	Was Dec		215	rigin? (Speci	ify Ves or N	0.	14. Bace	S.A.	an Indian	
	iten iten	Funeral I	1 ☐ Never Married 2	Married	12. Was Deceden Armed Forces 1 ☐ Yes 2 ∑	? <b>7</b> No		If Yes, sp	ecify Cuba	an, Mexica	rigin? (Speci an, Puerto Ri	ican, etc.)	<u> </u>		k, White,		,
36	s af	by F	3 √Widowed 4 □ D		If Yes, Give Year or Dates	•		1 🗆 Yes	2 <b>X</b> No	Specify	:		ľ	Specify	В1	ack	
215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	ğ	**				16a. Dece	dont'o Ho	ual Occur	ation			16h V	and of Du	-i/I	ali i alia i	
77	"na"	Completed	(Specify onl)	ecedent's Edu highest grade	e completed)		(Give	kind of w	ork done	during mo	st of working	7	100. K	ina oi bu	siness/Ir	uusiry	
2	vithir ne. <b>han</b>	립	Elementary/Secondary		College (1-4o	5+)											
21	filed v Hygie other t		6th grade		<u>na</u>			Nur	se A		tant					Dut	<b>У</b>
D	should be filed within and Mental Hygiene. marked other than matic event, the Me	Be	17. Father's Name (First, I	Viiddie, Last)						18. Moth	er's Name (	First, Middle	e, Maiden	Surnam	ie)		
ā	should be fand Mental Hand Men	- 1	Hurbert Fa	ulknei	s					Aga	ter E	Baker					
Maryland	2 sho and I Is ma		19a. Informant's Name/Re	elationship (Ty	pe. Print)		19b. Mailir	ng Addre	ss (Street		er or Rural			or Town,	State, Zi	Code)	
Σ	rte 27		Marie Anth	onv-D	aughter	•	4912	Ch	algr	ove	Ave,	Balt	i mo	re,	Ма	212	1.5
စ်	tem f He		20a. Method of Disposition				Place of Dispo cemetery, crei				Da					own, State	
9		Н	1 Burial 2 □ Cren			e (					70/0	7 /07				_	7
Ħ	t. P rtme rtani		4 Donation 5 □ C						wn		10/2	7707	Bal	Clmo	ore	Co,_	Ма
Baltimore,	permit. Pages 1 a Department of Hee Important: If Item any injury or othe		1. Signed up of Funeral S	Dervice Cicens	Bund	1	M   4	arc 300	h F/ Wab	ss of Faci H We	st Ave,	Balt	imo	re,	Md	212	215
	(a) (a)		23a. Part1. Enter the dise	ase, or compli	ications that caus	ed the deat										Approxi	mate Between
	Physician	Ÿ V		e. List offig of				- 1	1.							Unset a	nd Death
	/Medical	Ш	Imm. diate Cause (Final is se or condition ulting in death)			carl	al F	ntz	27	,						2	4/5
	Examiner	Ш			,		juence of):	-4-	-1							_	
E.		-	Sequentially list condition	s, t	Due to (or a	est v		//	191/4	1/6					_	<b>5</b> y	5.
	p Vis	ine	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	le d	Due to for a	s a conseq	position or).										
	ecut	Examiner	that initiated events resulting in death) Last		·												
0,	e ex ian a urial	<u> </u>	y and an analy and		Due to (or a	is a conseq	ruence of):										
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and X page 2 should be detached for use as the burial-transit	Medical			d												
99	tifica ng ph as tl	led															
Вох	eath cer attendir for use	5	IF FEMALE: 23b. Was decedent pregr	ant 2	3c. If yes, outcom			75					Į.	23d. Dat	e of deliv	ery	
m	death atte	Physician/	in the past 12 month 1 ☐ Yes 2 ☐ No		1□Live birth 4□Pregnant	at time of o		_lEctopic ☐ Other (	pregnancy specify)	У				Mo	nth	Day	Year
P.O.	the cy the chec	ıysı	9 Unknown		9□Unknown												
	uires that the de signed by the a Id be detached f	급	Part II. Other significant	conditions cor	ntributing to death	but not res	ulting in the u	nderlying	cause giv	en in Part	I.	23e. Did	tobacco	use cont	ribute to	the cause	of death?
Records,	sign sign be	by										10	Yes 2	□ No	3□ Pro	bably 4	□⊎πknown
0	w requir been si should	Completed															
ec	has b	ם										24a. Wa	s an opsy	24b. \	Were aut	opsy findi	ngs available of cause of
<b>E</b>	The arte h	0										per 1□ Yes	formed?	/ (	death?	2 No	
ita	ician; Th certificate ector, pag	Be	25. Was case referred to	medical						26. Plac	e of Death						
or Vital	ys S	10 E	examiner? 1 ☐ Yes 2 ☐ No	1	Hospital: 1 ☐ Inpa	tient 2	R/Outpatier	nt 3∐ I	OOA Oth	ner: 4 🗆 N	lursing Hom	e 5 Res	sidence	6 ∏Oth	er (Spec	fv)	
ō	3 Ph	<u>:</u>	27. Manner of Death		28a. Date of Ir	ijury	28b. Time o		28c. Injui Wor			3d. Describe				137)	
on	ding f h. After funer	ţ	1 ☑ Natural 5 ☐ 2 ☐ Accident	Pending investigation	(Month, E	Day Year)	Injury	М		rk? ∣Yes 2[	1No		-				
Division	I or Attending after death. Director: Afte I in by the fune	Certification:		Could not be	28e. Place of i	niunz - At h	ome farm str					3f. Location	(Street at	ad Numb	or or Pu	ral Pauta	Mumbor
<u>&gt;</u>	or A after Dire	ŧ	4 ☐ Homicide	determined	building,	etc. (Speci	fy)	cot, laot	ory, ornoc		20	City or To	own, State	) )	ei oi nui	ai noute i	vurriber,
	urs a		00- 0		I												
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 ☐ C (Check only 2 ☐ N	ertifying Phy- ledical Exami	sician: To the besiner: On the basis	of examina	owledge, deat ation and/or in	n occurre vestigati	ed at the ti on, in my o	me, date a opinion, de	and place, areath occurre	nd due to th d at the time	e cause(s e, date an	) and ma d place,	anner as and due	stated. to the cau	se(s)
	thin ; the mple	Mec	29b. Signature and title of	cartifier	and manner	siaieu.			9c Licere	se number			204 0	to cie	d /84a=4*	Day V	arl
	T wii		250. Signature and little of	unier /	1/1/	)							230. D8	.e signe (	u (IVIONTA	Day, Yea	11/
	b	l l	Mu	Cax	ne TV				H	43	157	-		101	22	07	
	4		30. Nam and address of	person who co	ompleted cause of	death (Iter	m 23a) (Type,	Print)	A 1								
	I	1 4	Tyle	Cy.	net D.C	2 '	2435	iv	Bilv	rdell	Av.	Suite	72	GIA	mon	MD	21215
1	Sta	te	31. Date filed (Month, Day	( Year)	32. Regis	strar's Sign	ature	17									

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State o	f Maryland		rtment of H tificate of L		and Mental H		0007	21.	722	
		Registrar  1. Decedent's Name (First, Middle	, Last)		Cer	uncate Of I	Jealii	2. Date of		1	3. Time (	of Death	
Physicia /Medic		Gary		D.		Johnson	1	Month 10	22			М	
Examin		4a. Facility Name (If not institution, 6225 York Rd.	_	mber) 204		4b. City, Town, or Balt	Location o			c. County of Dea			
Funeral Director		5. Social Security Number 213–80–9328	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. Ia	ast birthday) _ Yrs.	If Under 1 Year Months Days		24 Hrs. 8. Date of Month,	Birth <i>Day, Year</i> -1962	r)   C	irthplace (State Country)		
		Usual Residence of Decedent			Town or '	ration		1 2-1.					
f shov ed at	٥	Md. 10b. County	Ą		Town or Loc Baltin						10d. Inside City Limits 1  Yes 2  No		
r 28a- notifi	Director	10e. Street and Number	-			10f. Zip Code			10g. C	itizen of What C			
23a o		6225 York Rd.	Apt.	204		21239				USA			
ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	/ Funeral	11. Marital Status 1 【XNever Married 2 ☐ Marri	Armed Fo					gin? (Specify Yes or , Puerto Rican, etc.)	No-	Black, Wh	14. Race - American Indian, Black, White, etc.		
atural",	ted by	3 Widowed 4 Divorced  15. Decedent	Year or D	Dates:	16a, Deced	l ☐ Yes 2 X No lent's Usual Occup	Specify:		16b. I	Specify: B Kind of Busines			
Medi.	Completed	(Specify only highes Elementary/Secondary (0-12)	st grade completed) College (		(Give I life. E	kind of work done o OO NOT use retired	<b>during m</b> osi 1)	t of working					
her th		10th grade 17. Father's Name (First, Middle,	373		Di	sabled	10 84-11	r's Nama /Eim + ***		NA nn Surname)			
ls marked other thar aumatic event, the M	Be	17. Father's Name (First, Middle, Ernest	_aəlj	Wrig	h+			r's Name <i>(Fir</i> st, <i>Mide</i>	, Maide		ae:-		
Item 27 Is marke other traumatic	욘	19a. Informant's Name/Relationsh	hip (Type. Print)	wrig		g Address (Street		ary er or Rural Route Nu	nber, Citv	John: or Town, State,			
1, tr		Mary Ross	Mother		140	l N. Lak	ewood	Ave. Apt.	408	, Balti	more, M	d_ 2	
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		i State	ace of Dispos emetery, cren	sition (Name of natory or other plac	ce)	Date 2	20c. l	Location - City o	or Town, State	- EAT	
Important: If any Injury or once.		4 Donation 5 Other (S <sub>1</sub> 21. Signature of Funeral Service	Specify)	Ar		Mem. Parl		1026-07		butus, I	Md.		
any l		D Lad	z wo	me				March Ave., Bal			21202		
hysician and miner fransit meight	al Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, large, and list of the cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  ### Type How I or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											
attending phys for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 □Live 4 □ Preg 9 □ Unkr		death 3□ eath 5□	Ectopic pregnanc			_	23d. Date of d Month	Day	Year	
should be detached	δ	Part II. Other significant condition	ons contributing to c	death but not resu	alting in the ur	nderlying cause giv	en in Part I			us <i>e</i> contribute	to the cause o		
	lete	24a. Was an autopsy 24b. V								prior to death			
8 0	omp												
8 0	Be Completed	25. Was case referred to medical examiner?				1-	2051	1 ☐ Ye	es 2001 nly one		*		
certificate has rector, page 2	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 28a. Date	e of Injury	ER/Outpatien		ner: 4 🗆 Nu	1	es 2000 ely one) tesidence	1	*		
certificate has rector, page 2	To Be	examiner? 1 Yes 2 No	Hospital: 1  28a. Date (Mon			f 28c. Injur	ner: 4 🗆 Nu	a of Death (Check on ursing Home 5 DA)  28d. Descri	es 2000 ely one) tesidence	6 □Other (Sp	*		
certificate has rector, page 2	To Be	examiner? 1   Yes 2   No  27. Manner of Death 1   Natural 5   Pendin	Hospital: 1  28a. Date (Mor gation not be not be not be not be 128e. Place	e of Injury nth, Day Year)	28b. Time of Injury me, farm, stre	f 28c. Injur	ner: 4 □ Nu ryat rk?	e of Death (Check on ursing Home 5 1 4 28d. Descri	es 2000 aly one lesidence be how inj	6 □Other (Spijury occurred	pecify)	umber,	
certificate has rector, page 2	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pendin  2 Accident investit  3 Suicide 6 Could determ  29a. Certifier 1 Certifyir	Hospital: 1  28a. Date (Mori gation not be nined 28e. Place build ng Physician: To the Examiner: On the legal name of th	e of Injury nth, Day Year)  e of injury - At ho ding, etc. (Specify  be best of my know basis of examinat	28b. Time of Injury	f 28c. Injur Wor M 1 = eet, factory, office	ner: 4 Nu ry at rk? I Yes 2 I	e of Death (Check on ursing Home 5 1 4 28d. Descri	lesidence be how inj on (Street a Town, Sta	6 □Other (Sp. jury occurred  and Number or ate)  (s) and manner	pecify) Rural Route No		
certificate has rector, page 2	To Be	examiner?  1  Yes 2 No  27. Manner of Death  1  Matural 5 Pendin investig  2  Accident 6 Could 1  4 Homicide determ  29a. Certifier 1 Certifyir  (Check only 2 Medical	Hospital: 1  28a. Date gation not be nined 28e. Plac build ng Physician: To the Examiner: On the l and mai	e of Injury  nth, Day Year)  te of injury - At ho ding, etc. (Specify  te best of my know	28b. Time of Injury	f 28c. Injur Wor M 1 = eet, factory, office	ner: 4 Nu ry at rk? ] Yes 2  ime, date ar opinion, dea	e of Death (Check on ursing Home 5 1 1 1 2 8 d. Descri	lesidence be how inj on (Street a Town, Sta	6 □Other (Sp. jury occurred  and Number or ate)  (s) and manner	Rural Route No. as stated.	e(s)	
To the Funeral Director; After this certificate has been completely filled in by the funeral director, page 2 shou	edical Certification: To Be	examiner?  1  Yes 2 No  27. Manner of Death  1  Matural 5  Pendin investig  2  Accident 6 Could determ  29a. Certifier (Check only one)  1  Certifyir 2  Medical	Hospital: 1  28a. Date (Mori gation not be nined 28e. Place public nined 28e.	e of Injury nth, Day Year)  be of injury - At ho dding, etc. (Specify ne best of my know basis of examinat nner stated.	28b. Time of Injury me, farm, str. y) wledge, death	f 28c. Injury M 1 = 28c. Injury Wor M 1 = 28c. Injury Heet, factory, office	ime, date ar opinion, dea	of Death (Check on ursing Home 5 14 28d. Descri	lesidence be how inj in (Street and Town, State and the causeme, date and 29d. E	6 ☐Other (Sp. jury occurred  and Number or stee)  (s) and manner and place, and do contain the contain the contains the co	Rural Route Note as stated.	e(s)	
certificate has rector, page 2	edical Certification: To Be	examiner?  1  Yes 2 No  27. Manner of Death  1  Matural 5  Pendin investig  2  Accident 6 Could determ  29a. Certifier (Check only one)  1  Certifyir 2  Medical	Hospital: 1  28a. Date (Mori gation not be nined 28e. Place public nined 28e.	e of Injury nth, Day Year)  be of injury - At ho dding, etc. (Specify ne best of my know basis of examinat nner stated.	28b. Time of Injury me, farm, str. y) wledge, death	f 28c. Injury M 1 = 28c. Injury Wor M 1 = 28c. Injury Heet, factory, office	ime, date ar opinion, dea	of Death (Check on ursing Home 5 1 1 28d. Descri	lesidence be how inj in (Street and Town, State and the causeme, date and 29d. E	6 ☐Other (Sp. jury occurred  and Number or stee)  (s) and manner and place, and do contain the contain the contains the co	Rural Route Note as stated.	e(s)	

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Joseph Calvin Kelbaugh 09:15FM **OCTOBER** 26, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ▼ M 2 □ F Yrs. Director 217-20-1476 Feb. 23 1925 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show apy injury, or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits MD **Funeral Director** Baltimore Timonium 1 ☐ Yes 2√☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 Yorkview Drive 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 143-1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Completed by 3 Widowed 4 Divorced white '43-'46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a Owner/Proprietor Auto 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Kelbaugh မ Bertha Cole 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **Physician** /Medical

Examiner

burial-trar

Be

Certification: To 29a. Certifier Medical

25. Was case referred to medical examiner? 27. Manner of Death 1 Matural

1 ☐ Yes 2 No

2 Accident

3 ☐ Suicide

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OS

5 ☐ Pending investigation

6 ☐ Could not be determined

1 Inpatient

(Month, Day Year)

D. 7601

32. Registrar's Signature

28a. Date of Injury

signed to page 2 this after death filled in by

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

within 2.

State Registrar

	Mrs. Doris Kelbaugh/wife	23 Yorkview Drive,	Timonium, MD	21093
_	/ 4[Dopation/ 5 Defer (Specify) Du1	lace of Disposition (Name of	Date 20c. L	ocation - City or Town, State
-	21. Signature of Fune a Service Licensee	22. Name and Address of Facility		
	Lowell M. Lemmon	Lemmon Funeral F 10 W. Padonia Rd.	Home of Dulan Timonium,	ey Valley, Inc. MD 21093
	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. FROSTATE (Due to (or as a consequence))	. Do not enter the mode of dying, such as car	rdiac or respiratory arrest,	Approximate Interval Between Onset and Death 6 YEARS
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequen			
ysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
ed by Pr	Part II. Other significant conditions contributing to death but not resu END STAGE RENAL DISEASE	lting in the underlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?
ombiei			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify,

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

2 ER/Outpatient 3 DOA

Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D25886

OSLER DRIVE TOWSON, MARYLAND

1 ☐ Yes 2 ☐ No

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland f Desarthern of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 09an 2:00 P 10 /Medical 4c. County of Death cility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner deric timore 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** -934 Min. Months 1 □ M 2 ▼ F Days Hours 93 Director Usual Residence of 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at MD 1 Yes 2 No Director t more 10e. Street and Number 10g. Citizen of What Country? USA 21223 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) condary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: If them 27 is marked other the any Injury or other treasment. echnician reholo Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maide 19a. Informant's Name/Relationship 19b. Mailing Addre Rural Boute Number, City or Town, State, tarson 1 timore, 6td. Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐Removal from State 11-1-2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Licensee ne Funeral au Balti, Nat / 4i/e, Balto, MD ZI 23a. Part1. Enter the diveas shock, or heart lailure. ease, or complications that caused the death. Do not enter the mode of dying, are. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) THRIVE URF **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. detached 9 Unknown 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Tyes No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has page 2 autopsy perform certificate 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: ٩ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: eat 28b. Time of 28d. Describe how injury occurred After t 1 Natural 2 Accident Injury 5 Pending within 24 hours after death.

To the Funeral Director: Afcompletely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who campleted cause of death (Item 23a) (Type, Print) NROWINGRD filed (Month, Day, Year) State 30 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5 Per FH G8/3 11/09/Department of Health and Mental Hygiene
Certificate of Death Real No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician EVELYN** LABRADOR В. Oct. 27. 2007 9:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7975 Crain Highway Apt. Glen Burnie Anne Arundel 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 213–48–4502 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min, 8. Date of Birth (Month, Day, **Funeral** Days 1 □ M 2 1 F 76 Mar. 8, Director Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 1 □Yes 21XNo Director Maryland | Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7975 S. Crain Highway Apt. 316 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status e filed within 72 hours after de al Hygiene. other than "natural", or item Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: <u>Ş</u> Specify: 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other traumaric avent the 12 N/A Supervisor Sears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ William Garrity Lena Wassman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Golden Crown Way Pasadena, Maryland 21122 Jimmie Labrador (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/01/07 Glen Haven Mem. Pk. Glen Burnie, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Fuperal Service Licensee McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 then 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MINENO SC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No this certificate has autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 NResidence 6 Other (Specify) Hospital: 2No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient ပ 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and itle of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cohwad & 200, Glen Byrning nd PRAMILEZ

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Theresa Lesko /Medical of Death Facility Name (If not institution, give street and number) 4b\_City, Town, or Location of Death Examiner Raltimore rosedale ranklin Sq If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 28, 1936 Birthplace (State or Foreign Country) 5. Social Security Number L last birthday **Funeral** Months Days Hours 1 □ M 2 👽 207-28-2205 70 PA **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Baltimore MD Essex Director 1 ☐ Yes 27 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 610 Essex Avenue 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Giant Food Pharmacy Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Mehalsky Anna Lapinski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Lesko /husband 610 Essex Avenue Baltimore MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 10/30/07 Baltimore MD 4 ☐ Donation .5 Other (Specify) 21. Signature of uperal Service Lice vee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit and Due to (or as a consequence of). P.O. Box 68760 attending physician Physician/Medical the ! use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No Inpatient မ 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? or Attending 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar

State

29b. Signature and title of certifier

30. Name and address of person who compl

31. Date filed (Month, Day, Year)

NGUYEN

se of death (Item 23a) (Type, Print)

tran 32. Registrar's Signature

مران

29c. License number

D0065094

29d. Date signed (Month, Day, Year)

			For State	State of Mar		artment of H			000	01700
			1. Decedent's Name (First, Middle, Last)		061	- Illicale OI	Dealli	2. Date of Dea	Reg. No.	3. Time of Death
9	Physic		Dorothy K. Moore					Month	Day Year	
1	/Medi Examii		4a. Facility Name (If not institution, give s	treet and number)		4b. City. Town, o	or Location of Death	October	28, 2007 4c. County of Dea	12:30 A M
	Lxaiiii	iici	7950 Pipers Path	,			n Burnie		Anne Ar	
7	Funeral		5. Social Security Number 6. Sex		n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.		h 9. Bir	thplace (State or Foreign
	Director		216-03-0770	M 2XF 93	Yrs.	Months Days	Hours Min.	April 23	r, Year) C	ountry)
	Pu ,		Usual Residence of Decedent					777		
	anyla show d at	_	10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	he M 18a-f otifie	ecto	Maryland Anne Aru	nde1	Glen Bur					1 ☐ Yes 2 Ñ No
	death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	leath w ns 23a must k	eral	7950 Pipers Path	2 Mas Decedent Suc	zi=118 140 1	21061		7 V N	USA	-11
	item item iner	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Married 1	<ol> <li>Was Decedent Eve Armed Forces?</li> <li>1 ☐ Yes 2 XNo</li> </ol>	r in 0.5.	If Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puert	pecity Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi	
36	urs af	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
21215-0036	72 hours after natural", or ite iical Examine	ed	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Business	/Industry
215	within 7. iene. than "n he Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wor	rking		•
21,	d with giene er tha the	E O	10	College (1-401 54)	Во	okkeeper			Home Decor	ators
p	e file al Hy othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan		Maiden Surname)	
/lai	uld b Vienta Irked Itic e	10E	Millard F. Kohler				Dora A	rvin		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. once.	ľ	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Numbe	r, City or Town, State,	Zip Code)
	and and a		Richard W. Moore	Son	7950	Pipers H	Path; Gle	n Burnie	, MD 21061	
ore	of Her		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □ Re	- 1	<ol><li>20b. Place of Dispo</li></ol>	sition (Name of matory or other pla	i	Date	20c. Location - City or	
Baltimore,	permit. Pages Department of I Important: If its any injury or of		4 □ Donation 5 □ Other (Specify)	moval nom state	Good She	pherd	10/3	1/2007	Ellicott C	ity. MD
alt	permit. Departi Importa any inj		21. Signature of Funer. Service Licente		22	Name and Addre	ess of FacilitySte	rling As	hton Schwa	h Witzka
<u>m</u>	99 = 99	0.5	- Comments	_ Mol	290	uneral Ho 630 Edmor	ome of Ca ndson Ave	tonsvill nue: Cat	e, Inc.	MD 21228
10			23a Parti. Enter the disease, or complice shock, or heart ailure. List only one	ations that caused the cause on each line.	death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory an	est,	Approximate Interval Between
W	Physician		Immediate Cause Final disease or condition	Conge	chir he	art fall	lure			Onset and Death
	/Medical		resulting in death)	Due to (or a co		,				1 11
60	Examiner		Sequentially list conditions	Corer	any a	149 0	Usease	0		18 months
	P #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):	/				
	ecute and -trans	cam	that initiated events resulting in death) Last							
8760,	ate be executed hysician and the burial-transit	<u>=</u>		Due to (or as a co	onsequence of):					
87	cate be executed oblysician and the burial-transit	dical	d.							
9 X	The law requires that the death certifica tte has been signed by the attending pt age 2 should be detached for use as it	Physician/Me	IF FEMALE:	c. If yes, outcome of p	roananau					
Box	atten for us	ian	in the past 12 months?	1 ☐ Live birth 2 ☐	∃Fetal déath 3⊑	Ectopic pregnancy	у		23d. Date of de Month	livery Day Year
	the de	ysic	1  Yes 2	4□Pregnant at tim 9□Unknown	e or death 5∟	Other (specify) _				
P.0	that the dended by the stached is		Part II. Other significant conditions cont	ributing to death but no	ot resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ds	uires tha signed d be dei	d by	Chronic re	nul fair	line	. 0		1□Y		robably 4 □Unknown
Ö	w requir been si should i	Completed	Me as tead							
Re	has ge 2	Id III	174/10/2015/0r	)				24a. Was a autops perfor	sy prior to	utopsy findings available completion of cause of
a			05.34					1□ Yes	2 No 1 Yes	2 No
or Vital Records,	Physician: The la this certificate had ral director, page 2	Be	25. Was case referred to medical examiner?	spital:		t 3□ DOA Oth	ar	th (Check only or		
o	<u>а</u> + в	. To	1 ☐ Yes 2 ☐ No ☐ Ho	28a. Date of Injury	2 ER/Outpatien	, oll box	4 LI Nursing H		ence 6 Other (Spe	cify)
on	ding Ph h. After thi funeral	tiol	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day Ye	ear) Injury	Wor	rk? Yes 2 □ No	20d. Describe ik	ow injury occurred	
Division	Attending r death. ector: After oy the funer	Certification:	3 Suicide 6 ☐ Could not be	28e. Place of injury -	At home, farm, stre			28f Location (St	treet and Number or Ri	ural Route Number
Ö	after after Dire	erti	4 ☐ Homicide determined	building, etc. (5		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town	n, State)	arai rioate ivarioei,
	Hospital or A 24 hours after Funeral Dire etely filled in by		29a. Certifier 1 Certifying Physi	cian: To the best of m	y knowledge, death	occurred at the tir	me, date and place	and due to the c	ause(s) and manner as	s stated
	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Examine one)	er: On the basis of exa and manner stated	amination and/or inv	vestigation, in my c	opinion, death occu	rred at the time, o	late and place, and due	e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	-		29c. Licens	e number	2	9d. Date signed (Mont	h, Day, Year)
	1		Villeria Color	1, -			3/122		10/20h	7
_ `	1		30. Name and address of person who com	pleted cause of death	(Item 23a)./Type I		11100		/00/0	/
l	)		1417 Madican Par	L Dorwe	GHM	Burnie	MD.	21061		
	Sta	te	31. Date filed (Month, Day, Year)	32: Registrar's	Signature	369 10	1			
	Registr	ar	OCT 3 0 2007		A ARMS	A CONTRACTOR OF THE PARTY OF TH				

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MCCI

21229.

LAMICHHAME, DIMAN, 900 CATON AV, BALTIMORE,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State Amend 29c , per DVR, g872, 10/30/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 28 2007 Physician Month 12:50 PM ANCIS OCTOBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINA BAZTIMORE HOSPITAZ OF BALTIMORS 97 If Under 1 Year If Under 24 Hrs.

Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 2□ F Hours 215-16-2608 Director Usual Residence of Decec . it the Maryland r 28a-f show notified at 10a. State 10c Gity, Town or Location 10b. County 10d. Inside City Limits 1 ∏Yes 2 No Director MORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with or be . Was Decedent Ever in U.S. Armed Forces? 1.7 yes 2 □ No If Yes, Give Year or Dates: 36 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status "natural", or iter dical Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Specify: BIACK Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry

ROCK the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic ever P AWRENCE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a md +/ORENE : If item 27 or other t Baltimore, 20b. Place of Disposition (Name cemetery, crematory or other 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 Other (Specify) ings Mil 21. Signature of Funeral Service-Licensee BVC.T. UNERAL ONES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** troke WEEKS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2XNo 3 Probably 4 Unknown Completed 24a. Was an autopsy performed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No Division or Vital 2200 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes ≥ No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident Injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 Yes 2 No filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a, Certifier 🛌 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature/and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) MO Boy ou 200 OCTOR D65563 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD MORRISON-BRYANT HOSPITHZ OF 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

8

MILL

KNOSZ

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 October 22, 4:50 AMM /Medical James Mathis 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Southern Maryland Hospital 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 □ F unk Director 60 225-72-7120 July 8, 1947 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene.

ant: If tem 27 is marked other than "natural", or items 23a or 28a-f show ant: If them 27 is marked other than "natural" or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Clinton Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 9211 Stuart Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No black Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced unk unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) unk unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7503 Surratts Road Clinton, MD Southern Maryland Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page Department o Important: If I any Injury or once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify)in state 21. Si pature of Funeral Service Licens Ronal S. Wall 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street SA Director, 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause is each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumo **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trai Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autonsy page 1□ Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 pmpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 5 ☐ Pending investigation hours after death.

uneral Director: A
ely filled in by the fu 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 2 ☐ Medig 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 52741 10/22/01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Lingston Rd Ft Washington aroline arne 31. Date filed (Month, Day, Year) ≥2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

0

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

30

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 20051 0 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Ctr Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Yea 5/14/1941 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 ☐ F 66 Hours Min. 549-64-6700 Director Philippines Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show ms 23a or 28a-f shor must be notified at MD Anne Arundel Severn 1 TYes 2X No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1650 Shannon O Circle 21144 USA Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Asian ģ 3 Widowed 4 Divorced Completed Medicai 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than ' r traumatic event, the Me r than the Me Elementary/Secondary (0-12) College (1-4or 5+) Machine Company Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Diosdado Manansala Maximina Dumaquita ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Marlena A. Manansala/wife 1650 Shannon O Cir., Severn, MD 21144 item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ± 5 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 10/30/2007 Department of Important: If any Injury or once. Crownsville, MD MD Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature | Funarei San ce Licer 22. Name and Address of Facility
Singleton Funeral
2nd Ave SW Glen Burnie MD 21061 & Cremation Srvc M01364 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MYOCARDIOC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events could be act.) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ MA Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? sate has page 2 s autons TYPRITOPPRETE certificate 1 Yes 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Manner of eath funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury ours after death.

neral Director: A
filled in by the fu 1 🗌 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours at To the Funeral C completely filled i To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The cause(s) and manner as stated.

The cause(s) and manner as stated. 29a. Certifie Medical and manner stated. 29b. Signat 29c. License number on who completed cause of death (Item 23a) (Type, Print) 5 10CH18 (n, 0)31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

0

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

0 2007

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AKA Physician 25, Laverne Marie Hinch October 2007 4:48 PM Laverne Marie Hinch Meckoll /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 221 Booth Street #309 Gaithersburg Montgomery 8. Date of Birth
March 27, 1924 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 83 Country) California 1 □ M 2 13 F 566-26-4596 Director Usual Residence of Decedent 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 221 Booth Street #309 20879 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Willis Grannis P Minnie Effa Johnson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 War Admiral Court, North Potomac, Maryland 20878 Nancy M. Hoffman/ Daughter 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery
Crematorium Inc. 20a. Method of Disposition 20c. Location - City or Town, State October 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bethesda, Maryland 4 □ Donation 5 □ Other (Specify) 30, 2007 22. Name and Address of Facility Robert A. Pumphrey Funeral Home 21. Signature of Funeral Service Licenses Rockville Inc., 300 West Montgomery Ave. Rockville, Maryland 20850 Ejeva M01498 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pancreatic Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin J Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown Idiopathic Pulmonary Fibrosis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b autopsy performed' 1☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 ☐ No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 5 ☐ Pending investigation Injury To the Hospital or ....
within 24 hours after death.
To the Funeral Director: Aft 1 🖈 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0060044 October 29, 2007 CLY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Jesse Sadikman, M.D. 302 King Farm Blvd.#130, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

**ORIGINAL** 

MD 21201 Approximate Interval Between Onset and Death

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he provided one. Baltimore, Maryland 21215-0036

Physician /Medica Examine

and

**Physician** 

/Medical

Examiner

10a. State

MD

Funeral Director

Completed by

Be

P

**Funeral** 

Director

within 24 hours a

To the Funeral C

completely filled i

Hospital or Attending Physiclan: The law requires that the death certificate be executed

To the

Division or Vital Records, P.O. Box 68760.

	4 □ Donation 5 □ Other (Specify)	M.T. OF	IVET CEM.		07 WASHI		C
	21. Signature of Funeral Service Licensee	001	22. Name and Address of	Facility RONALD	TAYLOR,	II FH	
1	750 00	ex O?		RTH AVENUE			2120
٩	23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one c	ions that caused the death. Do not buse on each line.	enter the mode of dying, s	uch as cardiac or respirate	ory arrest,	Approxima	etween
	Immediate Cause (Final disease or condition	Myocard	ial end	nxc tim		Onset and	Death
	resulting in death)	Due to // r as a consequence of):	1 10	1		1	
١,	Sequentially list conditions, b.	Colesios	cleratio	C dis	ease.	> 4 ea	2S.
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	din Oli			1 1	2 -
	that initiated events c	Due to (or as a consequence of):	aropar	19		> yea	12.
				1	4	! [ [	
= 3	d						
W/W	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome pf pregnancy			23d. Date	e of delivery	
1.0	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	NA	Mor		Year
a d	9 □ Unknown	9□Unknown		( / (			
2	Part II. Other significant conditions contrib	outing to death but not resulting in the	e underlying cause given in	Part I. 23e.	Did tobacco use contri	bute to the cause of	death?
70	ena oray	1 ☐ Yes 2 ☐ No	3 ☐ Probably 4 S	nknown			
2	JEFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	enson.			Was an 24b. V	Vere autopsy finding	s available
į				1 V	performed?   d	eath? □Yes 2[ <b>X</b> No	
a	25. Was case referred to medical examiner?	nital.		. Place of Death (Check o	nly one)		
15	1 ☐ Yes 2 No Hosp	1 EH/Outpa		Nursing Home 5			
2	Natural 5 Pending	28a. Date of Injury 28b. Time (Month, Day Year) 28b. Time Injury	ry Work?		ribe how injury occurre	∌d	
100	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At home, farm,			on (Street and Numbe	or Pural Pouts Nr.	um ho v
ita	4 Homicide determined 2	building, etc. (Specify)	, on out, 140 ory, 011100		r Town, State)	i oi naiai nogle iva	mber,
2	29a. Certifier 1 Certifying Physicia	an: To the best of my knowledge, de	eath occurred at the time, o	late and place, and due to	the cause(s) and mai	nner as stated.	
Medical Certification: To	(Check only 2 Medical Examiner:	On the basis of examination and/or and manner stated.	r investigation, in my opinio	on, death occurred at the t	time, date and place, a	ind due to the cause	(s)
M	29b. Signature and title of certifier	110	29c. License nui	mber	29d. Date signed	(Month, Day, Year)	
	1 Jama	n / The	1 1196	509	10 20.	07.	
	30. Name and address of person who compl	leted cause of death (item 23a) (Typ	pe, Print) 3563	Perry	Street-		
	Thounk Jeainier  31. Date filed (Month, Day, Year)	32. I egistrar's Signatur	12				
ate	J. Date lileu (Worth, Day, Tear)	JE. PEUISITAL S SIGNATURA	NAME !				

egistrar's Signatur

OCT3 0 2007

State

Registrar

07-08296 Russell E. Nelson

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 34738

		- For State Certificate of Death	Reg. No.		
hysicia		1. Decedent's Name (First, Middle,Last)	ite of Death onth Day	Year	3. Time of Death 0949 hrs
Exami			tober 25, 20		
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	4	c. County of Death	
		Johns Hopkins Hospital Baltimore		- L - 5:	La La Contra de
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. If	Date of Birth (MM	Foreig	n l
Director		216-42-7751   TXM 2 F   62 Yrs.   Months Days Hours   Min.   S	ept.1,	1945 Co	untry) MD
	-	Usual Residence of Decedent			City Limite
È		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
_ 0w a		MD Baltimore Middle River			1 Yes 2 X No
yland yland tone	황	10e. Street and Number 10f. Zip Code	10g. Ci	tizen of What Cou	ntry?
or 28s	Director	8 Honeycomb Road 21220		USA	
th the 23a c		Lab Was Recordent Ever in U.S. 13 Was Decedent of Hispanic Origin? ( Specify	Yes or No-	14. Race - Amer	ican Indian, Black,
th wi	Funeral	1 Never Married 2 XMarried Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rica	n, etc.)	White, etc.	
5-0036 led within 72 hours after death with the Maryland bed within 72 hours after death with the Maryland lother than "natural", or items 23a or 28a-f show any the Medical Examiner must be notified at once.	교	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: Wh	ite
rs afte ural"	Completed by	Tor Dates:   Life Decedent's Lisual Occupation (Give kind of work)	done 16b	. Kind of Business	Industry
hour "nati	ted	College (1-4 or 5+)		Box Fac	tory
36 lin 72 than	l g	8th Machine Operator	_   _		
5-0036 iled within 7 Hygiene. I other than	팃	17. Father's Name (First, Middle, Last)  18. Mother's Name (First	st, Middle, Maide	en Surname)	
215 be filed antal Hy rked o	Be	Mildred	A. St	alnaker	
D 21215-0036 should be death with the Maryland and Mentel Hygien and Mentel Hygien or Tris market other Hygien and Mentel Hygien and Tris market other than "matural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	일	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural			
MD d 2 sho Ith and n 27 is		Patricia A. Nelson /wife 8 Honeycomb Road	Baltim	ore MD	21220
and and lealth item		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place)	ate 20	c. Location - City o	r rown, State
Baltimore, permit. Pages 1 at Department of Het Important: If ite		1 X Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 10	/30/97	Baltim	ore MD
ti. Partimer ritmer pritain		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300	Maco	Avo Ba	ltimoro MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygers. Important: If item 27 is marked other than "natural", injury or other traumatic event, the <u>Medical Examiner</u>		Connelly Funeral	Home of	of Esse	x 21221
ysician		23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or rec	spiratory arrest,	shock, or heart	Approximate Interval Between Onset and
/Medical		failure. List only one cause on each line.  Hypothopsive Atheros eleratic Cardiovas cular Disease			Death
Examiner	ı	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			
		Sequentially list conditions, b			
	ner	if any, leading to immediate Due to (or as a consequence of):			
	Examiner	(Disease or injury that initiated country that initiated country that initiated country that initiated country to the country			
msi god	ă	events resulting in death) Last Due to (or as a consequence of).			
760, refricate be executed physician and the burial - transit	g	UNPENDED AMENDED			
60, ate be o	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	
876 ifficat	≥		y	Month	Day Year
ox 68 eath certifi	icia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)			
Box 687 e death certifing the attending	Physician	1 Yes 2 No 9 Unknown 9 Unknown	23e. Did toba	cco use contribute	to the cause of death?
d by					robably 4 Unknown
, P.O rres that t signed by	d b		24a. Was an	9.544.554	autopsy findings available
ords, P ow requires the second of the description o	<u>e</u>		autopsy	prior	to completion of cause of
e law			1 Yes 2		
tal Rection: The certificate	ြပိ	25. Was case referred to medical 26.Place of Death (Check on	ly one)		
'ital siciar is cer	a	examiner? Hospital: Inserting 3 FR/Outpatient 3 DOA Other Nursing			ther:
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial that the fine of the most of director mass 2 the built he deathed for use as the built.	completely filled fill by the tuneral analysis, puge		8d. Describe ho	w injury occurred	
onding		1 Natural 5 Pending			
Atter	(c)	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2	8f. Location (Str or Town, Sta		Rural Route Number, City
Div	Certification:	3 Suicide 6 Could not be determined (Specify)	0/ 10///, 0/0		
Divisior To the Hospital or Attent within 24 hours after death To the Funeral Director:	ا ا		ue to the cause(	s) and manner as	stated.
the F	ical in	Certifying Physician: To the best of my knowledge, death occurred at the unite, date and place, and death occurred at the united at the	the time, date an	ia piace, and acc	
5 ki s	Medical	and manner stated.  29c. License number  29b. Signature and title of certifier		29d. Date signed	(Month, Day, Year)
-		O.C.M.E.		October 26, 2	007
· ·		30. Name and address of person who completed cause of death (Item 23a)			
4		Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, M	D 21201		
	Stat	31. Date filed (Month, Day, Year) 32. Registrar's Signature		OCME	

ORIGINAL

07-08300		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
Ozzie Edward Pa		Julia St. Managistania i September 1997	7 3473
		Reg. No.	. Time of Death
Physicia Medical Examin		Month Day Year	0925 hrs
<b>~</b>		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
		Johns Hopkins Hospital Baltimore	(9)
Funeral Director		C. Good Good in The Control of Good in the Co	olace (State or
Director	4	242-18-83 6 1 M 2 F 88 Yrs. Months Days Hours Min. 11 06 19 18 Porteign Cour	try) //
any	ŀ	Too. State	0d. Inside City Limits
*	٦	MD Baltimore	1 X Yes 2 No
Aaryla 28a-f	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country	y?
r death with the Maryland or items 23a or 28a-f show must be notified at once	₫	5607 Jonquil Avenue 21215 USA	
th with	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American White, etc.	in Indian, Black,
er dea			ick
2 hours after "natural",	g P	Tor pares:	tustry
6 72 ho un "na	pleted	Elementary/Secondary (0-12) College (1-4 or 5+)	9-11
5-0036 led within 72 Hygiene. other than	Comp	17. Fether's Name (First, Middle Apst)  18. Monther's Name (First, Middle, Maiden-Surname)	Stationard
215-( be filed ontal Hygorked oth	Be C	77. Father's Name (First, Middle Cast)  18. Mother's Name (First, Middle, Maider-Surname)  18. Mother's Name (First, Middle, Maider-Surname)  18. Mother's Name (First, Middle, Maider-Surname)	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	밁	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,	Zip Code)
MD id 2 sho flth and n 27 is		Darah L. Parker (Wite) 5607 Jonquil Ave, Daltimore, MD	21215
imore, MD 21215-0036  Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 'or other traumatic event, the Medical	-[	20a. Method of Disposition  20b. Place of Disposition (Name of Cemetery, Date 20c. Location - City or T crematory or other place)	own, State
altimore, mit. Pages I ar epartment of Hee portant: If ite		4 Donation 5 Other Specify: Harker family Cemetery 111107 Nashville	NC
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Med	[	21. Signature of Funeral Service Licenset 22. Natural Hidress Fac Greene Funeral Servi	21779
Physician	4	Vaugh ( , Villus 5151 Balts, Nat 11/2, Balts, Mi)  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	Approximate Interval
Medical		failure. Dist only one cause on each line.	Between Onset and Death
Examiner	-1	Immediate Cause (Final disease or condition resulting in death)  a. Attrefoscierotic Cardiovascular Disease Due to (or as a consequence of):	
		Sequentially list conditions,  b. Director of a consequence of the conditions of the	
	i e	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated C	
lsit ed /	Examiner	events resulting in death) Last Due to (or as a consequence of):	
and and	<u>a</u>	0.	
60, ate be	Ved	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
Box 68760, the death certificate be extitle attending physician ned for use as the burial	Physician/Medic	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Displayed to the past 12 months?	ay Year
Box c death c the attented for us	sici	1 Yes 2 No 9 Unknown Pregnant at time of 5 Other (Specify)	
O. E at the d by the stacked			
es the se the be de	d b		ably 4 🗹 Unknown
of Vital Records, ig Physician: The law requir Mer this certificate has been is meral director, page 2 should I	Completed	24a. Was an 24b. Were autopsy prior to co	opsy findings available ompletion of cause of
Recc The lav	E		2 No
Vital Recc ysician: The lan his certificate ha director, page 2	Bec	25. Was case referred to medical 25. Place of Death (Check only one)	
F Vit Physic arthis	P	1 V Yes 2 No Impatient 2 V ER/Outpatient 3 DOA 4 Norsing nome 5 Residence 6 Union.	
n of viding Ph. h. : After the funeral	<u>ë</u>	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	
Division Spiral or Attendii hours after death. ineral Director: /	ertification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rur	al Route Number, City
Div ital or urs aftural Di	E.E.	3 Suicide 6 Could not be determined (Specify) or Town, State)	
Hosp 24 ho Fune etely f	<u>a</u>		d.
DIVI To the Hospital or within 24 hours afte To the Funeral Dir	ledical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon	
	Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Mon  October 26, 2007	
		30. Name and address of person who completed clause of death (kem 23a)	
3		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta	ate	31. Date filed (Month, Day, Year) OCT 3 0 2007  32. Registrar's Signature	
Regist	rar	OCT 3 0 2007 Alexan D. Jones	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 1, 23a, PtII per me 1872, 10/30/07dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death Larry G. Porter Dav Month **Physician** 2007 ARAN 10 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA BAUNMINGE morumo Universi If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 5/26/1983 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 11 M 2□F Washington, DC Director 577-08-7767 Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2XXVo Director Maryland Prince George Fort Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be Funeral 9220 Fort Foote Road 20744 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Security Officer Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental I 1 and 2 should be 2 Larry Moore Marchell Porter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health au
Important: If item 27 is
any Injury or other trau Mary McKeever - Aunt 2209 Panola St., Tarbor, NC 27886 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ₭ Burial 2 Cremation 3 Removal from State 10/6/2007 Landover, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a. Part1. If there the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CAsiony opath **Physician** /Medical Due to (or as a consequence of) Examiner Masn vohuy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Artificial Heart Placed 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a Was an certificate 2 □ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 0 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No spital or Attendi nours after death. Ineral Director; ≠ y filled in by the fi 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (Munn) 12006 2237 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene St. Baltimore, Md. 21201 SALAH MULTIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State marke 3 0 Registrar

State of Maryland / Department of Health and Mental Hygiene

	, ,					
Certificate of Death	Reg. No.	2	Ω	0	-7	21.71
	2. Date of Death	4	U	U	1	3. Tuhe of Death
	October 24,	2	OC	ү <u>е</u> аі 7	r	10:00 a

/Medical Examiner

Director

Funeral

ρ

Be Completed

ပ

Examiner

Physician/Medical

Completed by

Be

P

Certification:

Medical

(Check only

29b. Signature and title of certifier

Harry Li, M.D.

31. Date filed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

3 0 2007

**Funeral** Director

and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. The This marked other than "natural", or items 23a or 28a-f show her tranmatic event, the Medical Examiner must be notified at Health em 27 I permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.

Baltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

The law requires that the death certificate be executed attending physician and for use as the burial-trar page 2 should After this or Attending

Division or Vital Records, P.O. Box 68760,

neral Director: Hospital

Jerome Charles Poist, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard 8610 Snowden River Pkwy, Apt. 108 Columbia 8. Date of Birth (Month, Day, Year) 1943 Mary Land If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min 63 212-42-4722 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Columbia MD Howard 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21045 United States 8610 Snowden River Pkwy, Apt. 108 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 □ Never Married 2 □ Married 1 ☐ Yes X☐ No White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse 12 Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy E. McCain Jerome Charles Poist, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Breeding/Companion 4722 Ruby Avenue Baltimore, Maryland 21227 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Meadowridge Memorial 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-29-2007 Elkridge, Maryland 4 Donation 5 Other (Specify) Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Type II Diabetes Mellitus 15 years Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Linter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive heart failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Chronic renal failure 24a. Was an autopsy performed?
1☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Coronary artery disease 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No 5 Aesidence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

341

DHMH 17 Rev 1/2001

Registrar

miD.

32. Registrar's Signature

29c. License number

D56531

8600 Snowden River Pkwy, Ste 301, Columbia MD 21045

29d. Date signed (Month, Day, Year)

October 25, 2007

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylar				Mental Hygi	ene 007	34742
	Physici		Decedent's Name (First, Middle, Last)     Edith Page			-		2. Date of Death Month October	17, 200 <sup>Year</sup>	3. Time of Death 2:00 AM M
	/Medic Examir		4a. Facility Name (If not institution, give			-	or Location of Deat		4c. County of Death	
	Funeral	14	Marley Neck Healt  5. Social Security Number 6. Sex		last birthday)	Glen B		8. Date of Birth	Anne Aru	ndel
	Funeral Director			]M 2∏F 84	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, May 20,	Year) Conn.	ecticut
	anyland show	-	10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	the M	recto	MD Anne Aru	indel	Pasade	10f. Zip Code	•		g. Citizen of What Cou	
	th with	a D	4439-1 Mountain Ro	ad			122		USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or Items 23e or 28e-f show emportent: If item 27 is marked other then "neturel; or Items 23e or 28e-f show importent: If items 25e or 28e-f show emportent: Items 25e or 28e-f show emportent: Items 25e or 28e-f show emportent in a page.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 Year or Dates:	1	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (S an, Mexican, Puer Specity:	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White Specify: wh:	, etc.
21215-0036	within 72 ho ne. hen "netur is wadical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	unk 1	6b. Kind of Business/Ir	ndustry unk
land 2	ild be filed v lental Hygie ked other t ic event, III	To Be Co	unk u  17. Father's Name (First, Middle, Last)  Joseph Charles Mi	nk tchell			18. Mother's Na	me (First, Middle, M lvia	aiden Sumame)	
Maryland	nd 2 shou lith and M 27 ie mar r treumat	_	19a. Informant's Name/Relationship (Ty) Robert Miller/gra					ural Route Number, t Pasadena	City or Town, State, Zi,	
Baltimore,	Pages 1 ar nent of Hea ant: If item ary or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 1 ☐ Donation 5 ☐ Other (Specify)		Place of Dispo cemetery, crer	sition (Name of matory or other plac	ce)	Date 2	0c. Location - City or T	own, State
Balti	permit. Departn Importe eny inju		21. Signature of Funcy I Service License na.Ld S. W	ade lirector	r St	Name and Address altimore,			Baltimore S	Street
	Physician /Medical		23a. Part I. Enter the disease, or complished, or heart failure. List only on Immediate Cause (Final disease or condition suffing in death)	EREBRO	h. Do not ent				SENT	Approximate Interval Between Drise and Death
760,	ate be executed hysician and he burial-transit he burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of):	AL I	HYP E	PTE	LSION	LOYFARS
.O. Box 68	death certific e attending p id for use as t	by Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Û No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	death 3	Ectopic pregnancy Other (specify)	′		23d. Date of deliv Month	rery Day Year
rds, P	quires that n signed b uld be deta		Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to t	the cause of death?
Il Records,	ysicien: The law requires that the is certificate has been signed by the director, page 2 should be detached.	Completed						24a. Was an autopsy perform	ed? prior to co	opsy findings available ompletion of cause of
Vita V	sicien: Th certificate rector, pag	Be	25. Was case referred medical examiner?	ospital:		Oth		th (Check only one,		
Division of Vital	Attending Physicien: r death. ector: After this certifice by the funeral director, p	tlon: To	1 Yes 22No  27. Manny of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at	10me 5 ☐ Residen 28d. Describe how	ce 6  □Other (Speci v injury occurred	<del>ý</del> )
Divisi	of or Attending after death.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	cician: To the best of my knower: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the ting restigation, in my o	ne, date and place pinion, death occu	e, and due to the cau arred at the time, dat	ise(s) and manner as s e and place, and due t	stated. o the cause(s)
	To the within To the comple	Ň	29b. Signature and title of certifier	In St n	D	29c Licens	e number	$\begin{array}{c c} & & & & & & & & & & & & & & & & & & &$	d. Date signed (Month,	Day, Year) 23,2007
_			30. Name and progress of person who con	mpletod cause of freath (libe	23a) N/pe,	SE SA	10 A.A.	AND	如 2122	HUMAY
	Sta Registra		31. Date filed (Month, Day, Year)  OCT 3 0 2007	32. Registrar's Signa	ture Ana	St. D				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 340 PURVIS  $\Delta M$ ADRIAN 10 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Hinore MERCY If Under 1 Year If Under 24 Hrs/ 8. Date of Birth Worth Day, mesical 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days 1 M 2 □ F 219-52-6110 Usual Residence of Decedent Director 10a. State Show 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Director 1 Nes 2 No Himore 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>\$</u> 3 ☐ Widowed 4 ☑ Divorced "natural", Completed traumatic event, the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College\_(1-4or 5+) filed within Hygiene. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f 2 ore Ha Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trauonce. DownersGrove Illinois 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1⊈Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) 107 ure of Funeral Service Licensee ie Fringral Services een M01363 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. OKO MO Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** FAILLRE disease or condition resulting in death) LIVER /Medical Due to (or as a consequence of) Examiner HEPATITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical the as use 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 0 9☐Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate or Vital 1∐ Yes 2 X No after death.

Director: After this certific 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Hospital: Inpatient 1 ☐ Yes 2 No Other: Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 1X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I Hospital Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 590 10/27/200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 BRIAN

State Registrar Eshars

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08164 State of Maryland / Department of Health and Mental Hygiene Marcus Pearson 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ Month Day October 20, 2007 0507 hrs **Medical Examiner** 4c. County of Death a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Johns Hopkins University Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Director Country) 1 XM Usual Residence of Deceder 10d. Inside City Limits 0c. City. Town or Location 10b. County 1 Yes 2 No 28a-f show narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-2. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married Armed Forces' Yes filed within 72 hours after Yes 2 No specify: Widowed Divorced f Yes, Give Yee. þ 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) timore, MD 21215-0036

1. Pages I and 2 should be filed within 72 harmon of Health and Mental Hygiene.
reant: If item 27 is marked other than " marked other than a 18.Mother's Name (First, Middle, Maiden Surname 17 Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, ို 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 26/07 Removal from State 2 Cremation 3 mportant: Other Specify ure of Funeral Service Licenses Approximate Interval such as cardiac or respiratory arrest, shock, or hea 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Sudden unexplained death in infancy Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed Physician/Medical X UNPENDED AMENDED 7,28a-f, perME, g875, ned by the attending physician detached for use as the burial -23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes Yes 2 No 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Be Division of Vital Other<sub>4</sub> Hospital: Nursing Home 5 Residence 6 2 Y ER/Outpatient 3 Inpatient 1 ✔ Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Natural Yes 2 X No Pendina ımk the Fnd 10/20/2007 Fnd 4:00 am 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be or Town, State) 5025 Plymouth Rd. Baltimore, MD Suicide thin 24 hours a (Specify) other-scene Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie October 20, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT OCME Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** John Foster Peacock, Sr 24, October 2007 3:30 P<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brightwood Center Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ₹ M 2 □ F 220-09-3932 86 December 08, 1920 Director Maryland Usual Residence of Decedent a or 28a-f show t be notified at 10a. State 10h County 10c. City. Town or Location 10d, Inside City Limits 1 ☐Yes 2XNo Director Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 515 Brightfield Road 21093 items 23a United States Of America Examiner must Funeral 12. Was Decedent Ever in U.S. Agned Forces? 1≦Yes 2☐No If Yes, Give Year or Dates:WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 6 1 ☐ Yes 2X No Specify: Specify: White ģ 3 Widowed 4 □ Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Engineering Building Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental I Unknown Unknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Joyce Klein (Daughter) 2 Folly Farm Ct., Reisterstown, Maryland 21136 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Metro Crematory Inc. 10/26/07 Catonsville, MD. 21228 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 8728 Liberty Road, Randallstown, Maryland 21133 3a. Part. Enter the disease, of block, or heart failure. mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Immediate Cause (Final Physician weole disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ebro vas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed attending physician and for use as the burial-trai Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has page 2 s autopsy perform death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ပို 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Hospital or Attending 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Andrew Thomas Peters, Sr. 12:25 P <sup>M</sup> October 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 83 Director 217-18-8202 1923 Dec. 11, Maryland Usual Residence of Decedent show ed at 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f sho notified a 1 ☐ Yes 2X No Director Maryland | Montgomery North Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 r must be n 8906 Montgomery Avenue 20815 United States Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or item edical Examiner Black, White, etc. 1 X Yes 2 □ No If Yes, Give WWII Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 💢 No Specify. White þ Specify: 3 Widowed 4 Divorced Completed the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) 12 Cabinet Maker Public Schools permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Thomas Peters Nannie Axie Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Lynn Peters Sherman/ Daughter 8906 Montgomery Ave., North Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Bethesda, Maryland 4 □ Donation 5 □ Other (Specify) Oct. 29, 2007 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on \_ach line. Approximate
Interval Between
Onset and Death
MOVINS Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 ☐ Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

burial-trar physician the buria Vital 0 this Hospital or Attending

· death v

filed within 72 hours after

3altimore, Maryland 21215-0036

items

the funeral director, after death. completely filled in by within 24 hours a To the Funeral I

Medical

15+1

Gabriel Peter Pushkas, 31. Date filed (Month, Day, Year) Registrar

30. Name and address of person who co

4 ☐ Homicide

29a. Certifier

29b. Sig



manner stated

11510 Old Georgetown Rd., Rockville, Maryland 20852

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

07-08235

William Franklin Rhoades

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 34748

		- For State Registrar				Certi	ficate of	Death			12	Date of D	Reg. No	D		3. Time	of Death
Physicia Examir	ın/ ner	1. Decedent's Name (Eirst, Middle Last) William Franklin Rhoades										2. Date of Death Month Day Year October 22, 2007				234	5 hrs
		4a. Facility Name (i 2817 Hamm	er)				city, Town, or Location of Death alethorpe				Baltimore County th(MM/DD/YYYY) 9. Birthplace (State or			State or			
Funeral Director		5. Social Security N 218-66-1		6. Sex	1	Age (In yrs. las	t birthday) Yrs.	If Under Months	1 Year Days	If Under	3.600			м/DD/YYYY 1962	Fore	ign ountry)	MD
21215-0036 July be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f show any event, the M. dieal Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of 10a. State MD  10e. Street and Nu 2817 F.  11. Marital Status 1 Never Marr 3 Widowed 15. Decedent's Elementary/Sec 12  17. Father's Name Ralph F.	Decedent  10b. County  Ba  Inher  Iammond  ied 2 X M  4 Dividucation (Special Condary (0-12)  Griff Record	Is Fernancial Is Fernancial Is Fernancial Is Fernancial Is Yes Corporation of the Island Is Island I	ry Roa Was Decedd Armed Force Yes s, Give Year atles: phest grade (1-4	ad ent Ever in U.S es? 2 No	13. Walling In 19b. Mailin	letho:  10f. Zip C  10f. Zip C  1s Decedent es, specify  Yes 2  1t's Usual O  1ost of work  Mecha	ode  2 t of Hisp Cuban, X No ccupatiting life. nic	specify: on (Give k DO NOT u  8. Mother's BeV	ind of wouse retired some some some some some some some some	ork done ed)  (First, Mid  Ann	r No-	14. Rac Whi Specify b. Kind of E Heavy den Surnam 11 r, City or To	ed.eed.ee-Americe, etc. Wh Busines Eq Down, Str.	1 Unity?  State erican Indi  ite s/Industry uipme	ent  ode)
Baltimore, I permit. Pages I and Department of Heall Important: If item injury or other training or ot	_	Patricia Rhoades - Wife  2817 Hammonds Fry Rd., Halethorpe, MD 21227  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  4 Donation 5 Other Specify  21. Signature of puteral Service Licensee  22. Name and Address of Facility  23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  20c. Location - City or Town, State  2127 Ambrose Funeral Home, Inc.  2719 Hammonds Fry Rd., Lansdowne, MD 21227  Approximate Interval Between Onset and															
ysician Medical Examine		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a Contact Gunshot Wound of Head  Due to (or as a consequence of):									Death						
xecuted and and a transit	cal Examiner																
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and a hearth he dearshof for use as the burial - transi	Develois as a Medical								Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Ye Other (Specify)						Year		
5.0. Bc that the dea ned by the a	by Dhys						resulting in th	the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown				
of Vital Records, P.O. Box 68' mg Physician: The law requires that the death certificate has been signed by the attending the certificate has been signed by the attending the control of the second o	, page 2 should be											.	autops perform	med?	pric	or to compl th?	findings available etion of cause of
	page	5	26.Place of Death (Check only one)														
ital I	S   C	25. Was case re examiner?			pital: 1	Inpatient 2	ER/Outpati	ent 3	DOA	Other <sub>4</sub>	Nurs	ing Home	5 🔲 I	Residence	6 🗸	Other: Sce	ene
	<u>.</u>	O 1 Ves 2 No 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury oc															
Division tal or Attendirs after death.	ed in by th	3 ✓ Suicide 6 Could not be determined determined (Specify) Single Family							ry, office	building,	etc.	2817 Hammonds Ferry Road, Halethorpe, MD					
he Hospit in 24 hour	completely filled in by	4 Homicio 29a. Certifier (Check only one) 2		Examiner: 0	n the basis	st of my knowle of examination	edge, death or and/or invest	ccurred at this	ne time, ny opini	date and on, death	place, ai	nd due to t	the caus ne, date	aria piace,			use(s)
To t with	com	29b. Signature		a	and manner stated.			29c. License number O.C.M.E.					29d. Date signed (Month, Day, Year) October 23, 2007			Day, Year)	
12×1		30. Name and Ling Li, I		rson who con	mpleted cau	use of death (It	em 23a) 11 Penn S	treet, Bal	timore	e, MD 2	1201						
	Sta	te 31. Date filed (	Month, Day, Y	ear)		egistrar's Sign		23 MAN									
Reg	तावा	<b>ा</b>	OCT 3	U ZUU	II A ho	57 R. E. S.	200										

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician 07 24 Mary B. Rosenberger 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale Daltimore FRANKLIN SQUARE HOSPITAL CENTER 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F Feb 6, 1928 Director 220-24-8734 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at MD 1√2 Yes 2 □ No Director Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 229 Sandhill Road 21221 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Harvey Cullen ဂ Ida Marie Deppish 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 229 Sandhill Road Baltimore, MD 21221 Elmer Rosenberger/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Si nature + Funeral Service Rona I d 22. Name and Address of Facility S. Wade, State Anatomy Board 655 W. Baltimore Street irector 21201 Baltimore, MD 23a. Part Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myocardial INFARCTION **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 1No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

osenberger

within 24 hours a er death To the Funeral Lirector: filled in by the Hospital the

determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

DRIVE

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

10,25,07

BALTIMORE Md 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR Candice Grordani 4000 FRANKLIN

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

OCT 3 0 2007

State Registrar

		State of State Please Type or Please Type of Please	Maryland / Dep	artment of Health	and Mental Hygie	ene						
			Ce	ertificate of Death		. No 2007 34750						
Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Death						
/Medi		William Roger Riehl		T		27 2007 2:14 AM						
Examir	er	4a. Facility Name (If not institution, give street and num.	ber)		4b. City, Town, or Location of Death 4c. County of Death							
	3	5. Social Security Number 6. Sex 7	'. Age (In yrs. last birthday	If Under 1 Year   If Unde	r 24 Hrs. 8. Date of Birth	Baltimore  9. Birthplace (State or Foreign						
Funeral Director		212-76-5220 125M 20F	50 Yrs.	Months Days Hours		ear) Country)						
		Usual Residence of Decedent			1104 20, 1	957 Maryland						
rylan how	_	10a. State 10b. County	10c. City, Town or L	_		10d. Inside City Limits						
e Ma 3a-f s tiffed	cto	Maryland Baltimore	i	Baltimore		1. ■Yes 2 □ No						
or 24	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Country?						
s 23a		113. N. Highland A.		21224		USA						
ier de Item	Funeral	Armed For	lent Ever in U.S. 13. ces?	Was Decedent of Hispanic O If Yes, specify Cuban, Mexica	rigin'? (Specify Yes or No- an, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.						
rsaff L', or xamil	by F	1 Never Married 2 Married 1 ☐ Yes 3 If Yes, Give Year or Da	es:	1 ☐ Yes 2 💢 No Specify	<i>y</i> :	Specify: White						
2 hou atura		15. Decedent's Education		edent's Usual Occupation		ib. Kind of Business/Industry						
hin 72 an "n Medi	To Be Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-	life.	e kind of work done during mo DO NOT use retired)	ost of working							
d with		10		Never Worke	ed	NA						
al Hy		17. Father's Name (First, Middle, Last)			ner's Name <i>(First, Middle, Ma</i>							
Ment Ment arked		William Roger Riehl	, Sr,	1	eona Mac	chlinski						
2 sh and is m raum		19a. Informant's Name/Relationship (Type. Print)	1			City or Town, State, Zip Code)						
l and lealth sm 27 ther t		Mark Sass - Brother  20a. Method of Disposition	20b. Place of Disp			Mills, MD 2/117						
ages if ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from S	cemetery, cre	ematory or other place)								
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 ♣Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Anatomy (	2 Name and Address of Earl	Uctober 2/, ZEO7 1	lanover, MD 21076						
Depa Impo any I		21. Signature du direita service Elerisee		572 Canal	Anatomy E	it P. HanoverMD 21076						
		23a. Part1. Enter the disease, or complications that ca	used the death. Do not er			Approximate						
Physician		shock, or heart failure. List only one cause on ea	A	WCER .		Interval Between Onset and Death						
/Medical		disease or condition resulting in death)  Due to (condition)	r as a consequence of):	HUCER		a years						
Examiner						U						
	ē	Sequentially list conditions, if any, leading to immediate  Due to (or	r as a consequence of):									
be executed sician and burial-transit	Examine	Cause (Disease or injury that initiated events c.										
e exe		resulting in death) Last  Due to (or as a consequence of):										
ficate by physical sthe p	Completed by Physician/Medical	d										
ding page as		IF FEMALE: 23c if was outc	ome pf pregnancy	1000-100								
leath certifica attending plant for use as t		in the past 12 months?	th 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year						
the d		1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown										
The law requires that the death certificate te has been signed by the attending physoage 2 should be detached for use as the		Part II. Other significant conditions contributing to dea	ath but not resulting in the	underlying cause given in Part	I. 23e. Did toba	cco use contribute to the cause of death?						
quires n sign					1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ U							
s bee					24a. Was an	24b. Were autopsy findings available						
The la					autopsy performe 1∐ Yes 2√	prior to completion of cause of death?  ☐ No						
	BeC	25. Was case referred to medical examiner?		26. Plac	ce of Death (Check only one)	200						
hysic his ce I direc	P.	Hospital'	patient 2 ER/Outpatie	ent 3 DOA Other: 4 N	lursing Home 5 ☐ Residen	ce 6 Sother (Specify) HOSPICE						
Ing P		27. Manner of Death 28a. Date of (Month)	f Injury 28b. Time ( , Day Year) Injury	Work?	28d. Describe how	injury occurred						
tend eath. tor: / the fu	cati	2 Accident investigation M 1 Yes 2 No										
or At after of Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
pital ours a reral		20.2 Cartifier Cartifying Physicians To the heat of my knowledge death accurred at the time date and all										
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	edical	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
To th within To th comp	Me	29b. Signature and title of certifier		29c. License number	290	I. Date signed (Month, Day, Year)						
		Dendall Vo	ellle	0 256	43 1	0/27/2007						
1		30, Name and address of person who completed cause	of death (Item 23a) (Type	, Print)	0 10	N 000 0 - 4						
1				U. Towsateur	mblud/ ba	2001W 21204						
Sta Registi		31. Date filed (Month, Day, Year)	gistrar's∕Signature	4 - 60 -								
- riogist	11.0	UCT 3 U 2007   ASS	THE AT AND	E A Came								

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** 200 O /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Howard County General Hospital Columbia If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) May 24, 1920 9. Birthplace (State or Foreign Social Security Number **Funeral** Mary Land 87 Director 220-01-3773 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan 28a-f show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified i 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 310 Glenrae Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 2 🔀 No 1 Never Married 2 X Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bridget Angela Clarke Dallas P. Crandell ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Glenrae Drive; Catonsville, MD 21228 Creston M. Smith, Jr. Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 1 Tx Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11/5/2007 Owings Mills, Maryland Garrison Forest 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature I For ral Service , MD 21228 1630 Edmondson Avenue: Catonsville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nevmonu /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the a page 2 should be detached? a∏lJnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 3□ DOA Certification: To Inpatient 2 ER/Outpatient After this 27. Manner of De Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

8186

32. Registrar's Signature

0

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Ralph Dean Swiney toper 24 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT BALTIMORE N/AAGNES HEALTheare 8. Date of Birth (Month, Day, Dec 26, If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number Funeral 1 X M 2 □ F Mary Land 1943 219-38-8443 63 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, ih Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 911 Maiden Choice Lane 21229 **USA** by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 1 Nes 2 No 1961 If Yes, Give Year or Dates: 1964 Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Swinev Blanche Williams ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Swiney, Wife 911 Maiden Choice Lane Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/25/07 Baltimore, Maryland Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 19 40
Thomas Gregor <sup>22, Name and Address of Facility</sup>
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Arterioselerotic Physician disease or condition resulting in death) Un lenous Due to (or as a conse uence of) /Medical Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nunsequer or off Examiner After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? death? 1 ☐ Yes To the Hospital or Attending Physiclan: The within 24 hours after death. To the Funeral Director, After this certificate to completely filled in by the funeral director, page 1□ Yes 2☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA 27. Manner eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Agner Homita
32. Registrar's Signature Kersen Avenue 31. Date filed (Month, Day) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Physician	Registrar      Decedent's Name (First, Middle, Last)  ANNA M. SPOOL	VIRE	00/11	ificate of D	-cum	2. Date of Death Month OCTOBER	Day Year	3. Firme of Death  12:50 P.M.
/Medical Examiner	4a. Facility Name (If not institution, give str		1	tb. City, Town, or l	ocation of Death	COTODER	4c. County of Deat	
Funeral Director	210-34-9955	/E M 2 XF 7. Age (In yrs. last 70		GLEN BU If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) 6/17/19	ANNE ARU Year) 9. Bird Co 37 MAF	INDEL hplace (State or Foreign buntry) RYLAND
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	12O3 CATHEDRAL DI  11. Marital Status  1 □ Never Married 2 □ Married  3 【 Widowed 4 □ Divorced	RIVE 2. Was Decedent Ever in U.S. Armed Forces? 1	13. Will 15 16 16 16 16 16 16 16 16 16 16 16 16 16	BURNIE  10f. Zip Code  2 106 1  as Decedent of His fes, specify Cubar  Yes 2 No  nt's Usual Occupat of of work done di o NOT use retired)  TRESS  Address (Street au CHO COVE	18. Mother's Name  IRENE  nd Number or Rura  DR • CRO	ng 11  (First, Middle, Me. C. LOBE)	6b. Kind of Business/ RESTAURAN aiden Surname) R City or Town, State, 2	rican Indian, e, etc.  ITTE Industry  IT
permit. Pages 1 a Department of He Important: if item any injury or oth	20a. Method of Disposition  M Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	mor	22. I		of Facility THI RAVEN BL	1/2007 E JOHNSON VD. TOW:	SON, MD	
Control of the property of the project of the proje	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.		ice of):	er, No	n-sma	ll cel	L	Inlerval Between Onset and Death
res that the death certifigened by the attending be detached for use as by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 W Unknown  Part II. Other significant conditions cont	c. If yes, outcome pf pregnancy  1 Live birth 2 Fetal de  4 Pregnant at time of deat  9 Unknown  Tibuting to death but not resulting	eath 3∏E h 5∏(	octopic pregnancy Other (specify)  erlying cause given	n in Part I.		23d. Date of de Month	Day Year
ing Physician: After this certifica Lineral director, Con: To Be C	25. Was case referred to medical examiner?	spital: 1 Inpatient 2 ER  28a. Date of Injury (Month, Day Year)  28e. Place of injury - At home building, etc. (Specify)	Bb. Time of Injury	3 DOA Other 28c. Injury Work' M 1 Y	at es 2 No	n (Check only one me 5 AResiden 28d. Describe hov	ed? prior to death?	icify)
To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 1	29a. Certifier (Check only one)  29b. Signature and title of certifier	clan: To the best of my knowle er: On the basis of examination and manner stated.	edge, death on and/or inve	stigation, in my op	number	red at the time, da	te and place, and du	th, Day, Year)
3	30. Name and address of person who con			PAtux	ent PKWy	. Coln	ubia, M	-29,2007 UD 21044
State Registrar HMH 17 Rev 1/2001	31. Date filed (Month, Day, Year)  OCT 3 0 200	32. Registrar's Signature	× Ap	refer				

			For State Registrar	State of Maryland		rtificate of L			eg. No. 2	007	34754
	Physicia	ın	1. Decedent's Name (First, Middle, L	Mary Katherine	Beal1	Smith		2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic	3	4a. Facility Name (If not institution, g	ive street and number)		4b. City. Town, or	Location of Death	CC TOBER		2007	3743 A
	Examin	er	NOZTH WELT ITOSF				ALLSTOWN			KTIMOR	£
abeter 7	Funeral Director			Sex 7. Age (In yrs. In 10 M 20 F 88	as <i>t birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apr 3,	Year)	Cour	lace (State or Foreign try) vland
	20		Usual Residence of Decedent					Apr 3,	1717		
	Marylan-f show	tor	10a. State 10b. County  Maryland Baltimo		, Town or Lo Balti					1	0d. Inside City Limits 1 □Yes 2∑No
	r 28a	Funeral Director	10e. Street and Number	Le County	_Dall1	10f. Zip Code		1	0g. Citizen o	of What Cour	try?
	th wit	a	6811 Campfield	Road		21	.207		Į	JSA	
	tems tems	nue	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)		lace - Americ lack, White,	
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2X No If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:		Spe	cify: Wh	nite
5-0	"natu	Completed by	15. Decedent's (Specify only highest of	Education grade completed)	16a. Dece	dent's Usual Occup	ation during most of workii f)	ng	16b. Kind of	Business/In	dustry
121	within ene. than	dw	Elementary/Secondary (0-12)	College (1-4or 5+)		Bookkeeper			Colo	d Stor	ase
g 7	filed Hygi other ent, tl	ပိ	17. Father's Name (First, Middle, La	st)			18. Mother's Name	(First, Middle, I			
lan	lid be fental rked o	To Be	Aloyisus Jeff	erson Beall			Kath	nerine H	fuller		
Maryland	should and Men s marke sumatic		19a. Informant's Name/Relationship		19b. Maili	ng Address (Street	and Number or Rura			vn, State, Zip	Code)
	ges 1 and 2 should it of Health and Men If item 27 is marke or other traumatic		Mary Dale Smith	(Daughter-in-L							
0	Pages 1 nent of H int; If ite iry or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	□Removal from State	emetery, cre	osition (Name of matory or other plac	e) !			n - City or To	
Baltimore,	permit. Pages Department of Important: If it any Injury or once.		4 □ Donation 5 □ Other (Spe				Grdns 10/				
Ba	permit. Pag Department Important: I any Injury o once.	), i		awson			WIEDEFELI Road, Ba			E, INC y <b>l</b> and	<b>2</b> 1212
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the death ly one cause on each line.	n. Do not en	ter the mode of dyin	ig, such as cardiac o	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_aurose	+					-	
	/Medical Examiner		Tooding in doding	Due to (or as a consequ							
		ē	Sequentially list conditions, if any, leading to immediate	b. Occurr Due to (or as a consequ	uence of):	a Julia	<i>y</i>				
/	cuted id ansit	Examiner	that initiated events	с.						1-1	
Ö,	tificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):	1,1					
68760,	ate be	edical		d							
			IF FEMALE:	23c. If yes, outcome pf pregna	incv				004	Date of dally	
Box	The law requires that the death cert tte has been signed by the attendin bage 2 should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	I death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>				Date of delive Month	Day Year
P.0	d by the	Phy	9/OUnknown  Part II. Other significant conditions		ulting in the s	ınderlyina çause aiy	en in Part I	23e Did tol	hacco use c	ontribute to t	he cause of death?
Records,	w requires that the deben signed by the should be detached	by	Tartii. Ottor significant condition	, continuating to accumulatine to the		and onlying daddo giv					oably 4 Unknown
ဝ၁	law re as bee 2 sho	Completed						24a. Was a		b. Were auto	ppsy findings available mpletion of cause of
Ě		Com						performula 1	med?	death? 1 □ Yes	
Vital	siclan: The law certificate has b irector, page 2 s	Be (	25. Was case referred to medical examiner?	11		l out	26. Place of Death	(Check only on	ne)		
0	ung Physician: The Ing. After this certificate ha funeral director, page	P	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 2	ER/Outpatie		4 🗆 Nursing Ho	me 5 Reside			(y)
O	ding F h. After funera	tion	1 Natural 5 Pending 2 Accident investigat	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No	ZOG. DESCRIBE IN	ow injury occ	Julieu	
Division or	or Attending Physician: after death. Director: After this certific i in by the funeral director,	Certification:	3 Suicide 6 Could not determine	be 28e. Place of injury - At ho	ome, farm, st			28f. Location (Si	treet and Nu	m <i>ber</i> or Run	al Route Number,
á	al or s after al Dire	Certi	4 Difformicide	building, etc. (Specify	у)			City or Tow	n, State)		
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)  1 ★ Certifying 2 ★ Medical Ex	Physician: To the best of my kno caminer: On the basis of examina and manner stated.	wledge, dea tion and/or i	th occurred at the til nvestigation, in my o	me, date and place, opinion, death occur	and due to the c red at the time, c	ause(s) and date and plac	manner as s ce, and due t	stated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date sig	ned (Month,	Day, Year)
			Defty sun	lurs		200	59736		Octob	n 29	2007
	3		30. Name and address of person wi	no completed cause of death (Item	n 23a) (Type			,			
		1 1	31. Date filed (Month, Day, Year)	1.59	mo.	na RTH	WEST /tosi	PITAL	5401	our	COURT ROAD
	Sta Registi		OCT 3 0 200	07 Asia Asia	ature	L.S					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#17 perFH C872 10/30/07 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 28 ay 4:15р. м 100th 2007 Said Μ. Dhia 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Baltimore Greater Baltimore Med. Center Towson 8. Date of Birth O4 To Year) 33 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex Country) Iraq Months Days Hours Min. 1 XM 2 ☐ F 74 579-64-9720 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Reisterstown MD Baltimore 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21136 2223 Knox Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Franklin Square Elementary/Secondary (0-12) College (1-4or 5+) Hospital 8yrs+ Doctor 12th grade 17 Father's Name (First, Middle, Last)

Mohammad

Mohammed Said Tuma 18. Mother's Name (First, Middle, Maiden Surname) Munira Wahab 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 2223 Knox Ave, Reisterstown, Md Layla Said Emge-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 10/29/07 Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Line Marchd Myno West 4300 Wabash Ave, Baltimore, Md 21215 Irome 23a. Part1 Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PROSTATE YEARS disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 Yes 2 No 9 Hunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 2 **1** No 1 ☐ Yes 1☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Hother (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 ☐ Accident (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner To the Rospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

iral", or Items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 2 and yn Jujury or other traumatic event, the Medical Examiner must be none.

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

Be

ဂ

Examiner

Completed by Physician/Medical

Medical Certification: To Be

29a. Certifier

(Check only one)

5 Registrar 29b. Signature and title of certifier

D64395

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

~

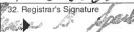
OCTOBER 29. 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 NCHARLES ST, SUITE 209 BALTIMORE, MB 21204 DANIEUE DOBERMAN, MO

1 Rertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, Year) OCT 3 0 2007



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death J3 Month **Physician** Mary Jane Stampone 07 10 /Medical 4a. Facility Name (If not institution; give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical ( Jalisburg Nicamico 5. Social Security Number egional If Under 1 Year | If Under/24 Hrs. 8. Date of Birth (Month, Day, Year) June 4, 1925 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours/ 1□M 2√F Wisconsin 392-20-7377 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Mortical Examiner must be notified at 1 ☐ Yes 2√ No Director Salisbury MD Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21801 105 Times Square Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 🎇 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 clerk magazine center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christina Marie Skildum Melvin Cornelius Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Cecil Street Salisbury, MD 21801 Deborah Taylor/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ∑Donation 5 ☐ Otheς (Specify) 21. Signature of Luneral Scale Licensee Kentral S. Walse, State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumom /Medical Due to (or as a consequence of): arclio veuscular Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed sician and burial-trans Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No Division or Vital Records, P.O. 9□Unknown 9 Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has be lirector, page 2 s autopsy performed? Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No within 24 hours after death.

To the Funeral Director; / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0063991 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415 S. OIVISION ST. Salisbury, MD VARADAKAJAN ANUPAMA 2. Registrar's Signature 31. Date filed (Month, Day, Year) OCT 3 0 2007 Registrar

DHMH 17 Rev 1/2001

393-20

			For  State Registrar	State of	Maryland / D	epartment				giene leg. No 2	07	34757
. 10°.	- X		Decedent's Name (First, Middle,	Last)					2. Date of Dea	ith		3. Time of Death
	Physici /Medio		Gabriel Pa	au1 Spa	ragana				October	25.	2007	3:45 P M
	Examir		4a. Facility Name (If not institution,			4b. City, 1	own, or Loc	cation of Death			nty of Death	
	>		2101 Tufton Ave					rstown			Baltim	
	Funeral		,	5. Sex 7. 1 X M 2 □ F	. Age (In yrs. last birt	hday) If Under Months		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)		place (State or Foreign ntry)
No.	Director		111-24-5318 Usual Residence of Decedent	-	75	115.			March :	28,193	2 New	York
yland	MO W		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
Mar	8-E	tor	Maryland Balti	more	Re	eisterst	own					1 ☐ Yes 2 No
th the	or 28	Director	10e. Street and Number			10f. Zip				10g. Citizen	of What Cou	ntry?
ath w	23a		2101 Tufton Av				2113				USA	
er de	He m	Funerai	11. Marital Status	12. Was Decede	es?	13. Was Deced	ent of Hispai fy Cuban, M	inic Origin? (Sp Jexican, Puerto	ecify Yes or No- Rican, etc.)	14. F	Race - Americ Black, White,	
1215-0036 within 72 hours after death with the Maryland	iene. r then "naturel", or iteme 23a or 28a-f ehow the Medical Examinet must be notified at	by F	1 ☐ Never Married 2 🙀 Marrie 3 ☐ Widowed 4 ☐ Divorced	If Vac Give	es: 1960–65	1 ☐ Yes 2	No S	Specity:		Spe	cify:	hite
1 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	Sture		15. Decedent's	Education		Decedent's Usua	Occupation	n .		16b. Kind of	f Business/In	
212 Thin 7	Med "n	pje	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4	lor 5+)	(Give kind of work life. DO NOT us	k done durin e retired)	ng most of work	ang			
d 21	Hygieni other the	Completed	12	5+		CEO/Owne	r			Jewel:	ry Man	ufacturing
		Be	17. Father's Name (First, Middle, La	ist)			18.	. Mother's Nam	e (First, Middle,	Maiden Sum	name)	
arylan should be	and Mental is marked aumatic ev	ဥ	Giovanni		Sparagana			Maria G				arelli
- CI	m = m		19a. Informant's Name/Relationshi			Mailing Address				•		
- and	Health em 27 ther tr		Diane M. Sparag	ana/Wife	20b. Place of	101 Tufted Disposition (Name	e of		eisterst Date		MD 21 on - City or To	
Pages	0		1 Burial 2 XCremation 3 4 Donation 5 Other (Spe		ate cemeter	y, crematory or ot	her place)	107	20/07			
			21. gnatus of Funeral ervice Li	00	Metro	22. Name and			29/07	Catons	sville	, Maryland
Bait Permit.	P F P		Bryan W. Cla	4 llest		Lemmon	Funer	ral Hom	e of Dul . Timoni	aney N	Valley	Inc.
F. 140			23a. Part1. Enter the disease, or coshock, or heart failure. List or	7	ed the death. Do n						210	Approximate Interval Between
Ph	ysician		Immediate Cause (Final disease or condition	ny one sausten as	COLO			CER				Onset and Death
1	Medical		resulting in death)	Due to (or	r.as a consequence of							11101111
E	caminer		Sequentially list conditions.	b								
p	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a consequence of	of):					The state of the s	
xecut	and Il-tran	хап	that initiated events resulting in death) Last	c	r as a consequence of	of):						
8/60, ate be executed	ohysicien and the burial-transit	dicai E				,						
ilicate	g phys as the	edic		u								
Geath certific	attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy	3 □Ectopic pre	anan.			23d.	Date of delive	эгу
deat C	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of death	5 ☐ Other (spe					Month	Day Year
at the C	by the a	Phy	9 Unknown									
Hecords, P.O.	signed b	by	Part II. Other significant condition	s contributing to dea	th but not resulting in	the underlying ca	use given in	n Part I.				he cause of death?
	should t	eted							-	es 2 No		
VITAL MECOLDS, ician: The law requires t	2 5	Completed							24a. Was a autop perfor	sy	b. Were auto prior to co death?	ppsy findings available impletion of cause of
	certificate ha rector, page	e Co	25. Was case referred to medical						1 Yes	2 No		2□ No
		To B	examiner?	Hospital:	patient 2 ER/Out	patient 3 DO	Othor	<ol> <li>Place of Deal</li> <li>Vursing Ho</li> </ol>	th (Check only or		Other (Specia	5-1
o P Phy	<del>⊆</del> =		27. Manner of Death	28a. Date of (Month,			Sc. Injury at Work?		28d. Describe h			y)
ld in	death. ctor: After / the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		Day rear)	njury M		2 □No				
DIVISION Lor Attending	- 0 A	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 289. Place 0	f Injury - At home, far , etc. (Specify)	m, street, factory,	office		28f. Location (S City or Tow		mber or Rura	al Route Number.
تَةِ ت	ral Di											
Hosp	24 hours Funeral letely filled	edicai	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the b	is of examination and	, death occurred a Vor investigation,	it the time, d in my opinio	date and place, on, death occur	and due to the or red at the time, o	ause(s) and late and plac	manner as s e, and due t	stated. o the cause(s)
DIVISION To the Hospital or Attending	within 24 hours effe To the Funeral Dir completely filled in	Med	29b. Signature applittle of certifier	and manne	stateu.	29c.	License nui	ımber	2	29d. Date sig	ned (Month,	Day, Year)
ř	s ⊢ ŏ		1/1/1/	ole 1	10			354		10/2	211	2007
1	D+1		30. Name and address of person w	ho completed cause	of death (Item 23a) (					/	-/-	
.A.			EWCOLE	ST AGN	ES 900	CATU	N AV	IE BI	ALTIMO	RE 1	MD	21229
	Sta		31. Date filed (Month, Day, Year) OCT 3 0 200	7 32. Rec	pistrar's Signature	sale o						
	Registr	ar	001 9 0 200	PORTE	No Poly	D. C. C.						

			1 - State of Man		artment of H			giene 200	7	34758
			Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	V	3. Time of Death
	Physici /Medic		Harley Snyder, Jr.				October	27, 20	0 <sup>Year</sup>	5:11 P.M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Dea	th	4c. County	of Death	
			Rockville Nursing Home		Rockvil1			Montg		
	Funeral Director		5. Social Security Number 6. Sex 1 図 M 2 日 F 7. Age (I	In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year)	Count	ace (State or Foreign try) Virginia
			Usual Residence of Decedent				10001 2	,		
death with the Maryland	show	_		Oc. City, Town or Lo	cation				10	od. Inside City Limits 1   Yes 2   No
he M	28a-f	Directo	Maryland Montgomery  10e. Street and Number	Rockville	10f. Zip Code			10g. Citizen of	What Count	
with t	a or		303 Adclare Road		20850			United		
death	тв 23	Funeral	11. Marital Status 12. Was Decedent Eve	er in U.S. 13.1	Was Decedent of H	ispanic Origin? (	Specify Yes or No	- 14. Ra	ce · America	an Indian,
after	ital Hygiene. id other than "natural", or items 23a or 28a-f show event. Ite Medicul Examiliar matte be mailited at		Armed Forces?  1 ☑ Never Married 2 ☐ Married 1 ☐ Yes, 2 ☑ No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	no Hican, etc.)	Bla	ck, White, e	
Within 72 hours after	ural',	d by	3 Widowed 4 Divorced Year or Dates:	355					Whit	
1 <b>3-</b> 1	"nat	lete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	durina most of wo	orking	16b. Kind of 8	iusiness/ind	ustry
Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z	iene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	None		-/		None		
0	al Hygie other	BeC	17. Father's Name (First, Middle, Last)	,		18. Mother's Na	me (First, Middle,	Maiden Sumai	ne)	
yland ould be fife	Menta arked	10	Harley Snyder			Margare	t Louise	Rogers	_	
Mar d 2 sho	is m		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street					Code)
<b>e, l</b>	ni of Health and Mental F t: If Item 27 is marked of y or other traumatic ever		Cecelia Seaton / Guardian  20a. Method of Disposition	20b. Place of Dispo	Duchess V	- NOTE - 1	Date	20c. Location		wn, State
nor ages	ant of it: If it y or o		1 ☐ Burial 2 MCremation 3 ☐ Removal from State	cemetery, crer Montgomery (	natory`or other plac "rematorium	1000	ober	Bethesd	a. Ma	rv1and
Saltimore	Department of himportant: If Ite any injury or ot once.		21. Signature of Funeral Service Licensee							11e, Inc.
ă ă			M S	00896 BO	U W. Mont	gomery.	Ave., Ro	ckville	, MD_	20850-2805
			23a. Part1. Ent a the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not ent	er the mode of dyin	ng, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	ysician		Immediate Cause (Final disease or condition resulting in death)  aCardiac	Arrest						Onsor and Doub
	Medical xaminer		Due to (or as a c	consequence of):	1 . 36					
	201	ē	Sequentially list conditions, if any, leading to immediate b. Cancer o	I COLON W	ith Metas	stasis				
りる	dansit	Examine	if any, leading to immediate cause. (Disease or injury that initiated events	Palsy						
5 %	ian an ırial-tr		resulting in death) Last Due to (or as a c	onsequence of):						
death certificate be executed	physician and is the burial-transit	dicai	d							
X O	attending p	/Me	IF FEMALE: 23c. If yes, outcome of	pregnancy				23d D	ate of delive	ary.
<b>BOX</b>	atten d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No	Fetal death 3	Ectopic pregnancy Other (specify)	/				Day Year
	by the	hys	9 Unknown							
Ords, P.O	been signed by the s should be detached	ام	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause giv	en in Part I.				ne cause of death?
COLO W requir	plnot	ted	Hypothyroidism				10	Yes 2 🔀 No	3 [] Prob	ably 4 □Unknown
§ G	S C	Completed					24a. Was autor		Were autor prior to cor death?	psy findings available inpletion of cause of
al The	certificate rector, pag						1 ☐ Yes	2⊠ No	1 Yes	2 No
OT VITAL	is certific director.	o Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital:   I patient	2 ER/Outpatier	nt 3 DOA Oth	er	eath (Check only of Home 5 Resi		har (Snacih	v)
o e	h. After this of funeral dir	h-	27. Manner of Death 28a. Date of Injury			y at		how injury occu		7
No night	oath. or: Aft he fun	atio	2 Accident investigation	oar) Injury		Yes 2 □ No				
UIVISION I or Attending	irecto n by t	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc.	- At home, farm, str (Specify)	reet, factory, office		28f. Location (. City or To		ber or Rura	l Route Number,
	eral D		29a. Certifier 1⊠ Cartifying Physician: To the best of	mu knowledge, deat	h occurred at the time	mo date and place	and due to the	cause(s) and m	anner as st	tated
e Hos	within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 ☑ Cartifying Physician: To the best of ( (Check onty one) 2 ☐ Madical Examinar: On the basis of examinar:	xamination and/or in	vestigation, in my	ppinion, death occ	curred at the time,	date and place	, and due to	the cause(s)
To th	within To th	Me	29b. Signature and title of certifier		29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)
			Mouras V. Di	ouph	D004	47330		October	29,	2007
	1.		30. Name and address of person who completed cause of dea			#007 D	-1	Va 1	J 00	0.50
	્ર		Thomas V. Joseph, M.D., 50  31. Date filed (Month, Day, Year)  32. Registrar's	W. Edmons	ton Dr.	FZU/, Ko	ckville,	maryla	na 20	534
ă	Sta Registi		OCT 3 0 2007	s Signature	3465					

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

**ORIGINAL** 

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

OCT3

0

2007

ULMay

Garage)

32 egistrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. ANTIN TIPM CORE PHYSE CATTER 10/30 AT A and Mental Hygiene - State Registrar Amend #18, perFH, g873 11/15/07 TT Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Doloves Waltman 11:00 A M 27,2007 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 321 Magothy Beach Road Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1□M 2X1F Director 215-28-1339 76 Mar. 12,1931 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Anne Arundel Pasadena Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 660 C Street 21122 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental 8 int: If item 27 Is marked of Hardy, Sr. Lula **Zell Unkown** ပ Harry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trains Christine L. Burrhus (Daughter) 321 Magothy Beach Road Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 10/30/07 Baltimore, Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena. Maryland 21122 21. Signature of Funeral Service Licensee Ulins 23a. P. z. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sill ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrovascular accident **Physician** ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 ☑Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 The sidence 6 Other (Specify) Daughter 's 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatuse and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) KIMO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pasadena Beach Rd Easleymo 24A Magetting Susan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#1 per PHYS G872 10/30/07 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death James Williams **Physician** JAMC 2.2007 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Tenesis Ommon 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1**X**M 2□ F Months Min. 082-24-1687 Director May Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Baltimore 1 Yes 2 □ No by Funeral Director MD10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2526 Edmondson Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Black Specify: 3 ☐ Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) lerih Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If Item 27 Is marked of Anne Diggs Unhnown 19b. Mailing Address (Street and Number or Rural Houte Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edmondson Avenue Baltimore mo 21223 trancesca Moseborough Daugher 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State nant 10.24.07 Baltimore, 22. Name and Address of Facility Vaughn C. Green function 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 5151 Boutimore National Pile Baltimore mo 2009 auch Noone Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) SEFSIS WK **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No 1☐ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2000 1 🗌 Inpatient 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Pritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the I within 2 and manner stated To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number My 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Rd. Coforguille NO 21228 1009 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

0

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0.25.2007 Saiah Wimple 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Gilchrist Baltimore OWSON 8. Date of Birth (Month, Day, Year) 04.10.192 If Under 1 Year 9. Birthplace (State or Foreign Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Days Min 239.36.2484 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XiYes 2 □ No timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2307 Masher 21216 12. Was Decedent Ever in U.S. Amed Forces? 1 M Yes 2 □ No HYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1□Yes 2No Specify Blach Specify. 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ACME Supermarket 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WimPle rnma 19b. Mailing Address (Street and Number or Rural Route Number, 19a, Informant's Name/Relationship (Type. Print) Thosedale MD 21237 Daughter laylor Date Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10.30.07 Laurel, Maryland 22. Name and Address of Facility Varyhn C. Green Juneral Service 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pile Bultimore mo 2100 Immediate Cause (Final disease or condition resulting in death) YEARS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ nknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3□ DOA 1 ☐ Yes 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

**Examiner** The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician:

After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran within 24 hours after death To the Funeral Director: filled in by the Physician/Medical Examiner

Completed by

Be

Certification: To

29a. Certifier (Check only

29b. Signature and title of

Physician

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Funeral Director

þ

Completed

Be 10

artment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1
Department of H
Important: If Itel
any Injury or ott

Physician /Medical

3altimore, Maryland 21215-0036

the

State

Registrar

31. Date filed (Month, Day,

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year) OCTOBER 25, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 6565 A N CHARLES ST SUITE 209 BALTIMORE, MIS 21204 DANIEUE DOBERMAN: MS



# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygienes of Type Please Type or Print in Black Indelible Ink.

		for State Registrar	State of Mary		ertificate of			Reg. No.	7 34764
Physici	an	Decedent's Name (First, Middle, Last)     MARIE CATHERINE	E MADD				2. Date of Dea Month	Day Yea	
/Medic		4a. Facility Name (If not institution, give s			4b. Citv. Town, o	r Location of Death		26, 2007	6:20 A. <sup>M</sup>
Exami	iei	1654 MUSSULA ROAD	,		TOWSO			,	IMORE
Funeral		5. Social Security Number 6. Sex	7. Age (la	n yrs. last birthd	ay) If Under 1 Year		8. Date of Birth (Month, Day		Sirthplace (State or Foreign Country)
Director		212-12-1792 Usual Residence of Decedent	86	5 Yrs			11/17/		ARYLAND
land ow		10a. State 10b. County	10	c. City, Town o	Location				10d. Inside City Limits
n the Marylan r 28a-f show notified at	tor	MD BALTIMO	DRE	TO	WSON				1 □ Yes 2 <b>□</b> KNo
ith the or 28%	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What	Country?
ath wi 23a ust b	ral	1654 MUSSULA ROAD			212			USA	
er de: items ner m	Funeral		2. Was Decedent Ever Armed Forces?	r in U.S.	<ol><li>Was Decedent of H If Yes, specify Cuba</li></ol>	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	nerican Indian, hite, etc.
.0036 hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ <b>X</b> No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	WHITE
<b>215-0036</b> thin 72 hours after death with e. an "naturat", or items 23a or Medical Examiner must be.		15. Decedent's Educ (Specify only highest grade	ation	16a. De	ecedent's Usual Occup	ation	[	16b. Kind of Busines	ss/Industry
Vithin 72 ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	- lii	e. DO NOT use retired  HOMEMAKER	1)	ang	OLINI LIOMI	<b>.</b>
N p 5 5 7		6TH GRADE  17. Father's Name (First, Middle, Last)			HOMEMAKER		a /Finak kkindula	OWN HOM	<u>.                                    </u>
yland yland buld be file Mental Hy arked oth atic event	Be C	FRANCIS HENRY WAF	onic				e (Filst, Middle, 1 ETH C. F	Maiden Surname)	
	P.	19a. Informant's Name/Relationship (Typ		19b. M	ailing Address (Street				, Zip Code)
Magazine 27 ls		NANCY GROSS/DAUGHTE	R	165	O MUSSULA	ROAD TO	VSON, MD	21286	
or He of He rothe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	2	20b. Place of Di	sposition (Name of crematory or other place	i	Date	20c. Location - City	or Town, State
IIMOF		4 Donation 5 Other (Specify)	emovar from State	MOST HO	LY REDEEME	10/2		BALTIMORE	•
Baltimore, permit. Pages 1 a Department of Hee Important: If item any injury or othe		21. Signature of Funeral/Service.Li / nse	e / - / h// (	~ M3.	TERY 22. Name and Addre				L HOME, P.A.
402.00		23a Part Enter the disease or complice	etions that caused the		8521 LOCH				21286 Approximate
Dhualalan	0.0	23a Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final			enter the mode of dyn	ig, such as cardiac	or respiratory arr	est,	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a co						3 Ments
Examiner		Sequentially list conditions b.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
/p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (piscase or injury that initiated events continued to the condition of the conditions of the condi	Due to (or as a co	nsequence of):					1
and -trans	Examiner	that initiated events c.	Due to (or as a co	neconianos ofi:					
ficate be executed physician and is the burial-transit	a E		Due to (or as a co	misequence or).					
rificate be executed by physician and as the burial-transit	fedical	d.							
BOX sath cert attending for use a	In/M	200. Was decedent pregnant	c. If yes, outcome pf p		2			23d. Date of d	delivery
ed for u	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at time		3 □Ectopic pregnancy 5 □ Other (specify) _			Month	Day Year
The law requires that the law requires that the las been signed by the lage 2 should be detache	Phy	9 Unknown				- i- D- + i	oo- Dida-	h	4.41
dS, irres the signer of be d	þ	Part II. Other significant conditions conf		FTN	e undenying cause giv	en in Part I.	23e. Dia tol		to the cause of death?  Probably 4 Dunknown
Hecords, he law requires t has been signe ge 2 should be o	Completed	Garage J. Tooley	Dia	~ 1.vc					
he lav e has	mp	UNITED THEST INTO	- 156	-D/WO-			24a. Was a autops perfor	med2 death	autopsy findings available o completion of cause of ?
VITAL Iclan: T certificat ector, pa		25. Was case referred to medical	1 INTECT	1/av		26. Place of Deat	1□ Yes	2 No 1 L Y	es 2 No
ysici ysici iis cer direct	o Be	examiner? _	ospital: 1   Inpatient	2 ☐ ER/Outpa	tient 3 DOA Oth	0.51		ence 6 Other (S)	pecify)
ng Phy ng Phy ifter this	J:UC	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time				ow injury occurred	,,
SION tending leath. tor; Afte the fune	catic	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □ No			
lor At after of Direc	Certification:	4 ☐ Homicide determined	28e. Place of injury - building, etc. (S	At home, tarm, pecify)	street, factory, office		28f. Location (St City or Town	treet and Number or n, State)	Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death cerwithing 4 hours after death.  To the Luneral Director. After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	<u>S</u>	29a. Certifier 1 Certifying Physi	cian: To the best of m	y knowledge, de	eath occurred at the tir	ne, date and place,	and due to the c	ause(s) and manner	as stated.
n 24 h	Medical	(Check only 2 Medical Examin	er: On the basis of exa and manner stated.	amination and/o	r investigation, in my o	pinion, death occur	red at the time, d	date and place, and d	ue to the cause(s)
To ti To ti Comp	ž	29b. Signature and title of certifier	$\gamma I$ .		29c. Licenso		2	29d. Date signed (Mo	nth, Day, Year)
		· C/M/	MID		1 0	3//89	0	0 crosel 26	, 2007
(0)		30. Name and address of person who con		2710			0	- 43	21-24
Sta	te	MCGGAR J- MINSON 31. Date filed (Month, Day, Year)	32. Pegistrar's		Mar Wood	10/ 1	BATTALOR	e; 110 2	1237
Registr		OCT 3 0 200	Bester	J. J.	meste				

State of Maryland / Department of Health and Mental Hygiene 34765 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 27, 2007 **Physician** 5:15 ам James Francis Waters, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Sex f□M 2□F Funeral Months Days Hours Min 213-34-7317 69 Director July 2, 1938 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10h County 10d Inside City Limits 10a State items 23a or 28a-f shov ner must be notified at MD Baltimore Baltimore Highlands 1 ☐Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 2723 Norfen Road U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ural", or item Black, White, etc and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🔯 If Yes, Give Year or Dates: 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: white 3 Widowed 4 □ Divorced or other traumatic event, the Medical Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Printer Printing Company 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Woods William Waters ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 Concord Lane Berlin, MD 21181 lealth am 27 i James Waters, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Memorial
Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 10-30-2007 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ambrose Funeral Home of Lansdowne repe 2719 Hammonds Ferry Rd. Lansdowne MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760; Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Year Day 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 1 □Yes 2 □ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe certificate 1 ☐ Yes 2 ☐ No 1∐ Yes 2**X** No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural
2 Accident 5 Pending investigation ours after death.

neral Director: At filled in by the fur 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dav. Year) 29b. Signature and title of pertifier 29c-license number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 82. Registrar's Signature State

Registrar

3 0 200

OCTOBER

			1 - For State Registrar	State of Ma	aryland / De <i>C</i>		nt of H		d Mental Hy	giene	7007	34	766
	Physici		Decedent's Name (First, Middle, La  Robert Lee Wes						2. Date of D Month	eath Day	Year	3. Time o	of Death
	/Medic Examir		4a. Facility Name (If not institution, give			4b. Cit	y, Town, or	Location of D	Octobe		2007 County of Death		Ор
	ZX		313-B Jonathan	Street		Н	agers	town			Washing	ton	
	Funeral Director		5. Social Security Number 6. S 215-88-1348	Sex 7. Age 1⊠M 2□F	(In yrs. last birthda 69 Yrs.	Month	er 1 Year s Days	If Under 24 Hours A	Hrs. 8. Date of B (Month, C	ay, Year)	Cou	place (State intry)	or Foreign unk
	pur M		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location						10d. Inside C	City Limite
	death with the Maryland ms 23a or 28a-f show rmust be notified at	5											s 2 No
	28a-	Director	Maryland Washin 10e. Street and Number	igton	Hagers		Zip Code			10g. Citi	zen of What Cou	intry?	
	h with		313-B Jonathan	Street		2	1740				SA		
	ems .	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?		3. Was Dec	edent of Hi	spanic Origin'	? (Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Amer Black, White		
0000	ours after ral', or It	b	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	o unk		2∏ No	Specify:	dono i noan, etc.,		Specify: b1		
	be filed within 72 hours after death with the Marylan ital Hygiene. ed other then "natural; or Items 23s or 28s-f show other, the Madical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	(Gi	ve kind of v	ual Occupa vork done d use retired,	luring most of	working unk	16b. Kii	nd of Business/li	ndustry	unk
7	giane grane er tha	Com		unk	T/								
and	ould be file Mental Hy arked oth atic event	o Be	17. Father's Name (First, Middle, Last	)			unk	18. Mother's	Name (First, Middle	e, <i>Maid</i> en	Sumame)		unk
Mary	d 2 sh th and th and 7 Is m traum		19a. Informant's Name/Relationship (						r Rural Route Num				
lore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other ti		Anna M. Johnson/s  20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	20b. Place of Dis cemetery, c	position (A	ame of		et Hagers		cation - City or T	740 own, State	
Saitimoi	permit. Pa Departmen Important any Injury		4 □Donation 5 ☒Other (Special 21. Signature of Fune and Service Licer Ronald Service Licer Ronald Service Licer Ronald Service Licer Ronald Service Ronald Ronald Service Ronald Ron			22. Name State	and Addres Anato	s of Facility Omy Boa	ard 655 W	. Bal	timore S	Street	
	40244		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused	the death. Do not e	Baltin enter the m	nore,	MD 21 g, such as car	201 diac or respiratory	arrest,		Approxima Interval Be	ite
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	b	a consequence of):	- LE	<u></u>	dis i	Taranh	Din	en	Onset and	1
,007	icate be executed physicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):								
O. DOX 0	To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death.  After the Funeral Birector: After this certificate has been signed by the attending pompletely filled in by the funeral director, page 2 should be detached for use as sompletely filled in by the funeral director, page 2 should be detached for use as sompletely filled in by the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of the little birth 4 □ Pregnant at 9 □ Unknown	2 Fetel death	3 □Ectopic 5 □ Other (				2	23d. Date of deliv Month		Year
ָרָ אָרָ בּי	w requires that been signed by should be deta	þ	Part II. Other significant conditions of	contributing to death bu	it not resulting in the	underlying	cause give	in in Part I.		tobacco u	se contribute to	the cause of	
מכסומ	sician: The law rec certificete has beei lirector, page 2 shou	Completed	oftender	Pulmen	Dire	an,	ober	~15	24a. Wa auto	s an opsy ormed?	24b. Were aut prior to co death?	opsy findings ompletion of i	available cause of
<u> </u>	in: Th		25. Was case referred to medical						1 ☐ Yes	2 1 No	1 ☐ Yes	2 □ No	
>	/sicia s cert directo	To Be	examiner?	Hospital:	nt 2 ER/Outpat	iont 3 🗆 I	Othe		Death Check only	/	CO*bas (C	£.1	
5	ding Phys h. After this funeral di		27. Manher of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		of	28c. Injury Work		28d. Describe			ry)	
21212	or Attan after deal Director: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e One Place of Inju	ry · At home, farm, . (Specify)				28f. Location City or To	(Street and own, State)	d Number or Rur )	al Route Nur	nber,
-	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Continue Processing Process	nysician: To the best of the basis of and manner sta	examination and/or	ath occurre	d at the tim	e, date and pl	lace, and due to the	cause(s) , date and	and manner as place, and due	stated. to the cause(	s)
	o the	Mec	29b. Signature and title of certifier	anu manner sta	100.	2	9c. License	number		29d. Date	e signed (Month,	Day, Year)	
	⊢s⊢ŏ		- conti	<b>N</b> D				3019			T 23		>
			30. Name and address of person who	completed cause of de			ERS	70 W.	~ mo		740		
3	Sta Regístr		31. Date filed (Month, Day, Year) OCT 3 0 2007	32. Registra		age B						4 646	-

			1 - For State Registrar	State of	Marylar		artment of H	Health and M <i>Death</i>		giene 0	07	347	67
	Physic		1. Decedent's Name (First, Midd				TAMO		2. Date of Dea Month October		2 <b>Ŏ</b> Ů7	3. Time of 1	Death Av
	/Medi Examir		KAMERON  4a. Fecility Name (If not institutio	n, give street and num		WILL	IAMS 4b. City. Town. o	or Location of Death			ity of Death		
	LAGITIII	ICI	Greater Baltin	-		er	Towson			Balt			
	Funeral		5. Social Security Number	6. Sex 7	7. Age (In yrs.		If Under 1 Year		8. Date of Birtl (Month, Day			lace (State or	Foreign
	Director		NONE	1 🟋 M 2 🗆 F		Yrs.	Months Days	Hours Min.	October		M		
_	pue *		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	cation					0d. Inside City	. I Imito
	Aarylen I show	ō	MD								1	1 Tyes	
	vith the Maryle 1 or 28a-f show 28 notified at	Director	10e. Street and Number		R	ANDALLS	10f. Zip Code			10g. Citizen o	f What Cour		
4	ith with 23a or		8905 HARKATE	T-77\ \7				22122			· · · · · · · · · · · · · · · · · · ·		
4	ter death	Funeral	11. Marital Status	12. Was Deced	dent Ever in U	.S. 13. V		21133 Hispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-	USA 14. Ra	ace - Americ	an Indian,	
و کے	urs efter death v al', or Iteme 23e Exert cor must		Never Married 2 Mar	Armed Ford	2 No				Rican, etc.)		ack, White,	etc.	
≥ 50	ours iral',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dat	tes:		☐ Yes 2☐ No	Specify:		Spec	BLP	CK	
△ <u>₹</u>	within 72 hours efter death with the Maryland ene. than "natural", or feme 23a or 28a-f show ha Mudical Examinar must be notified at	Completed	15. Deceden (Specify only highe	t's Education st grade completed)		(Give	ent's Usual Occup	during most of worki	ing	16b. Kind of	Business/Inc	Justry	
7 5	iene. r than	mp	Elementary/Secondary (0-12)	College (1-	4or 5+)		00 NOT use retired NFANT	d)		т.	NFANI	1	
Q 0	Hygin the		17. Father's Name (First, Middle,	1		T	NEANI	18. Mother's Name	(First, Middle.				
<u>a</u> ( )		To Be	UNKNOWN					ASHLE			WILLI	AMS	
Z Z	S D E E	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (Street	and Number or Rura					
₹ ×	7 a 7		SBMC TATU	woody		670	IN, a	MRLES S	T. Ras	to M	D 2	1204	
ore,	Se 1		20a. Method of Disposition	200		Place of Dispos	sition (Name of atory or other place	ce)	Date	20c. Location	- City or To	wn, State	
	Pag nent int: I		1 ☐ Burial 2 Cremation '4 ☐ Donation 5 ☐ Other (S	3 ∐Hemoval from St pecify)	tate	REEN	MOUNT	10/27	12007 [	Atin	MORP	MD	
alt	permit. Pa Departmer Important any injury		21. Signature of Funeral Service	Licensee			Name and Addre	ss of Facility	1624	YORK &	D	,	
.>=	20129		* 4-41 /	MACU		P	MRYW Je	AKINS WONS	s. Man	Kion :	S am	1111	
			23a. Part1. Enter the disease, of shock, or heart failure. List	complications that cau	used the deatl ch line.	h. Do not ente	r the mode of dyin	ng, such as cardiac o	r respiratory arr	est,		Approximate Interval Between	reen
	Physician		Immediate Cause (Final disease or condition	-a ext	rme	Prom	tunty	1				Onset and De	int
	/Medical Examiner		resulting in death)	Due to (or	r as a conseq	uence of):		/				11	-17
		_	Sequentially list conditions,	b	VI (	1/1	compa	MACR				1 day	1
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	8	as a consequ	uence or,						•	
	be executed sician and burial-transit	xar	that initiated events resulting in death) Last	CDue to (or	r as a consequ	uence of);							
8760,	cate be ex physician the burial	dicail		C <sub>d</sub>									
9	The law requires thet the deeth certificate ate hes been signed by the attending phys page 2 should be detached for use as the												
Вох	eeth certifi attending   i for use as	by Physician/Me	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna		Ectopic pregnancy	,		23d. D	ate of delive	ry	
	the atte	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of de		Other (specify)	· · · · · · · · · · · · · · · · · · ·		N	lonth	Day Ye	ear
P.0	thet the de led by the a detached t	Phy	9 Unknown										
	ires the signed I be det		Part II. Other significant condition	ns contributing to dear	th but not resu	ulting in the un	derlying cause give	en in Part I.				e cause of dea	
oro	w requir been si should	eted							1 🗆 Ye	as 2 No	3   Prob	ably 4 □Un	ıknown
ec e	e law hes b	Completed		-					24a. Was a autops	v	prior to cor	osy findings av	vailable use of
	olclan: The certificate rector, pag								perform 1 ☐ Yes	No No	death?	2 🗆 No	
Vit	sician certif rector	Be	25. Was case referred to medical examiner?	Hospital:			3□ DOA Oth	26. Place of Death					
o to	Phy r this ral di	٠ <u>.</u>	1 Yes 2 No  27. Manner of Death	1 <b>1</b> Inp		ER/Outpatient 28b. Time of	3LI DON	4   Nuising Non	ne 5 🗌 Reside 28d. Describe ha			)	
ion of	Attending Phyelclan: r death. sctor: After this certifically the funeral director.	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investig	28a. Date of (Month,	Day Year)	Injury	28c. Injun Worl	k? Yes 2 □ No		w injury cood			
Division of Vital Records,	Atter r dea ector by the	ifica	3 Suicide 6 Could r	ot bo	f Injury - At ho	me, farm, stre	et, factory, office	2	28f. Location (St	reet and Num	ber or Rura	Route Numb	er,
Ţ	s afte	Certification:	4   Hornicide	building	i, etc. (Specify	")			City or Towr	n, State)			
<u>p</u>	To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		(Check only 2) Medical i	g Physicien: To the be Examiner: On the basi	est of my know	wledge, death	occurred at the timestigation in my or	ne, date and place, a	and due to the ca	ause(s) and m	nanner as st	ated.	
<del>हा</del>	the hin 24 the F	Medical	0110)	and manner	r stated.	GITWOT HIVE							
	With Con.	-	29b. Signature and title of certifier	50			29c. License	e number	2	9d. Date sign	ed (Month, I	ley, Year)	
		-	J 43/07	rgu of			050	0076		10/6	77/(	1+	
5				who completed cause							0100		
	Stat	e	JOAN BLOMOUTAT, 31. Date filed (Month, Day, Year)	M.D., 656 32. Abg	9 N.CH istrar's Signat		ST., SUIT	re 307, ba	ALTIMORE	C, MD	21204		
	Registra		OCT3 0	2007	ر مینون	J 19	A State of the sta						

			1- For State of Maryland Registrar		artment of F		nd Mer		giene Reg. No.	2007	347	768
	Physici	ian	1. Decedent's Name (First, Middle, Last)					Date of De	eath Day	Year	3. Time of	Death
	/Media		Mary Frances Weil				00	tobe	r 28,	2007	6:37	A. M
	Examir	1er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		Death			County of Death		
			Montgomery Hospice Casey House  5. Social Security Number 6. Sex 7. Age (In yrs. las	t hirthday)	Rockvil: If Under 1 Year		Hre o	Date of Bir		itgomer	<u></u>	
	Funeral Director		214-34-6295 1 M 2 2 F 71	Yrs.	Months Days		Min.	(Month, Da	y, Year) 193	Cou	place (State o intry) ington	
i i			Usual Residence of Decedent				00	L. U	, 173	y wasii	Ting Com	, D.C.
	how Lat	_	10a. State 10b. County 10c. City, T	own or Lo	cation						10d. Inside Cit	-
	Ba-f s	Director		ville							1 X Yes	2 No
	vith the	Dire	10e. Street and Number		10f. Zip Code					en of What Cou		
	sath v	Funeral	10914 Bloomingdale Drive  11. Marital Status 12. Was Decedent Ever in U.S.	10.1	20852		0.1011	VN		d State		
_	item item Iner	E	11. Marital Status  1 □ Never Married 2 ☑ Married  1 □ Never Married 2 ☑ Married	13. V	Was Decedent of H f Yes, specify Cuba	an, Mexican, P	Puerto Rica	n, etc.)	).   14	Black, White		
20	ursat al',ol Exam	P	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1	1 ☐ Yes 2 ☑ No	Specify:			5	Specify:	White	
3-003p	72 ho natur ical i	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Deced	lent's Usual Occup	ation	f warking		i	d of Business/Ir		
V	ithin an	d d	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done of NOT use retired				۱ -	gomery (	-	
7	lled w Hygiel her tl ht, th	ဒီ		ssist	ant Jury					it Cour	rt ————	
aud	d be fintal hed of	Be	17. Father's Name (First, Middle, Last)			18. Mother's			, Maiden S	urname)		
Ž	should od Me mark matic	은	Irby N. Copeland  19a. Informant's Name/Relationship (Type. Print)	19h Mailin	g Address (Street	Anne C			er City or	Town State Z	in Cada)	
2	nd 2 s ulth ar 27 is r trau				Blooming							52
กั	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at	0.8	20a. Method of Disposition 20b. Plac	e of Dispo:	sition (Name of natory or other place	20)	Date		20c. Loca	ation - City or T	own, State	
=	Page nent c nnt: If iny or		Denai 2 Community 3 Chemoval from State		orial Park		v. 2, 2	2007	01nev	y, Mary	land	
Dalitillor	permit. Pages 1 an Department of Heal Important; If Item 2 any injury or other once.		21. Signature of Funeral Service I Ir ensue		Name and Addre							ne
_	8 3 5 6 6		M00896	5 30	0 W. Mont	tgomery	Ave	., Ro	ckvil	le, MD	20850-	2805
			23a. Part1. Enter the disease, or complications that caused the death. I shock, or heat failure. List only one cause on each line.	Oo not ente	er the mode of dyin	ng, such as car	rdiac or re	spiratory a	rrest,		Approximate Interval Bety	veen
	Physician	W O	Immediate Cause (Final disease or condition resulting in death)  Metastatic Paresulting in death)	ancre	atic Cano	cer					Onset and D	eath
	/Medical Examiner		Due to (or as a consequen	ce of):								
		<u>-</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequen	ce of):								
6.	uted I Insit	Ē	Cause (Disease or injury							- 4		
ָב ב	exec an and rial-tra	Examiner	that initiated events resulting in death) Last Due to (or as a consequen	ce of):								
,007	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d									
5	ertifica ing ph	Med	IF FEMALE:								0.0	-
	ath ce	jan/	23b. Was decedent pregnant in the past 12 months?	ath 3 🗆	Ectopic pregnancy	,			23	d. Date of deliving Month	,	'ear
5	he de the a	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown	1 5	Other (specify)					WOTH	Duy	Cui
_	that t ed by detac		Part II. Other significant conditions contributing to death but not resulting	g in the ur	iderlying cause give	en in Part I.		23e. Did t	obacco use	e contribute to	the cause of de	eath?
3	w requires that the death certific been signed by the attending p should be detached for use as t	d by						1 🗆 '	Yes 2□	No 3 □ Pro	bably 4 <u>√</u> U	nknown
5	aw rec	lete					_ +	24a. Was	an	24b. Were aut	opsy findings a	ıvailable
	The law te has	Completed					-		rmed?	prior to co death?	ompletion of ca	use of
5	ian: rtifica ctor, p	O	25. Was case referred to medical examiner?			26. Place of	Death (Cf		2 <b>X</b> No	1 ☐ Yes	2 No	
>	hysic his ce I direc	To B	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ EPA	'Outpatient	t 3□ DOA Othe	er: 4 ☐ Nursir	ng Home	5 ☐ Resi	dence 6	☑Other (Speci	Inpati <sub>fy)</sub> Hosp	ice
=	or Attending Physician: The infer death. Director: After this certificate he in by the funeral director, page in by the funeral director, page		27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year) 28. Date of Injury (Month, Day Year)	b. Time of Injury	28c. Injury Work	y at </td <td>28d.</td> <td>Describe I</td> <td>how injury</td> <td>occurred</td> <td></td> <td></td>	28d.	Describe I	how injury	occurred		
2	ttend Jeath. stor: / the f	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 380 Place of injury. At home			Yes 2 □ No						
	or A after of Direction by	Certification:	4 ☐ Homicide determined 28e. Place of injury - At home building, etc. (Specify)	, tarm, stre	et, factory, office		28f.	Location (S City or Tol	Street and vn, State)	Number or Rur	al Route Numi	per,
	spital ours neral filled		29a. Certifier 1 ☑ Certifying Physician: To the best of my knowle	dge, death	occurred at the tin	ne. date and p	place, and	due to the	cause(s) a	ind manner as	stated.	
:	To the Hospital or Attend within 24 hours after death.  To the Funeral Director: A completely filled in by the fi	edical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or inv	restigation, in my o	pinion, death o	occurred a	at the time,	date and p	lace, and due	to the cause(s)	)
1	Withii To the COTIF	Me	29b. Signature and title of certifier		29c. License					signed (Month,		
			Inourse Wrolker w.		D0064	+615			Octob	er 29,	2007	
	14		30. Name and address of person who completed cause of death (Item 23									
	1.1		Gehevieve Anne Wroblewski, M.D.,  31. Date filed (Month, Day, Year)  32. Registrar's Signature			er Mill	Rd.	, Roc	kvill	e, Mary	land 2	0855
	Sta Registra		31. Date filed (Month, Day, Year)  CCT 3 0 2007  32 Registrar's Signature	As DE	well .							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Wheeless Darrell 24,2007 October /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner George If Under 1 Year | I Onder 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** M 2□F Months Days Hours 577-86-8773 Director 50 11-22-56 DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at X□Yes 2□No Director MD P.G <u>Kettering</u> 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20774 62 Herrington Drive U.S.A Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black altimore, Maryland 21215-0036 1 □ Yes 2√2 No Specify: þ 3 ☐ Widowed 4 ☑ Divorced Year or Dates: "natural", the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Guard SupervisorAdmiral Security years 27 is marked other er traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert H. Wheeless Mary Lee Dunston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 39424 Baltimore MD 21212
patien (Name of Date 20c. Location - City or Town, State Department of Health Important: If Item 27 any injury or other tr once. Pamela Wheeless/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Park Crem. 10-30-07 Riverdale, MD
22. Name and Address of Facility Ronald Taylor II Funeral Hm 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service Licensee ana() West North Ave. Baltimore, MD 21201 75 108 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Atheros cleratic /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician end s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 DER/Outpatient 1 Yes 2 No 1 Inpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 5 ☐ Pending investigation 1. Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours arter co...
To the Funeral Director: Aft

> State Registrar

DHMH 17 Rev 1/2001

one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4



3001

29c. License number

29d. Date signed (Month, Day, Year)

			For State of Maryland / [	Department of Health and M	lental Hygier	
			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. I	
ı	Physic /Medi		TONETTE WILKINS			Day Year 7:15 PM
	Exami		4a. Facility Name (If not institution, give street and number)  MUNU MCCLCO CLUBER	4b. City, Town, or Location of Death		4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir		8. Date of Birth	Birthplace (State or Foreign
	Director		217-80-4352	Yrs. Months Days Hours Min.	9-28-196	Maryland
	yland how at		10a. State 10b. County 10c. City, Town	n or Location		10d. Inside City Limits
	he Mar 8a-fsl otified	Director		imore		1 X Yes 2 □ No
	with the sa or 2 the notes	Dir	10e. Street and Number 5004 Orville Avenue	10f. Zip Code	10g. (	Citizen of What Country?
	death	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	21205  13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	USA 14. Race - American Indian,
36	be filed within 72 hours after death with the Maryland tral tyliene. All Hyliene. And other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	rican, etc.)	Black, White, etc.  Specify: White
215-0036	72 hou natura lical E	eted		Decedent's Usual Occupation  (Give kind of work done diving most of work)	16b.	Kind of Business/Industry
121	within ene. <b>than</b> "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of worklife. DO NOT use retired)	Ι,	
1d 21	e filed with Il Hygiene. other thar /ent, the M	Be Co	17. Father's Name ( <i>First, Middle, Last</i> )	egal Secretary 18. Mother's Name	(First, Middle, Maid	Legal en Surname)
ylar	should be nd Mental marked o umatic eve	To B	Norman Clavey		Tamani	
Maryland	permit. Pages 1 and 2 should by Departit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		Norma Clavey-Mother 21	Mailing Address (Street and Number or Rura $8~S$ . East Avenue	al Route Number, Cit Baltimo:	y or Town, State, Zip Code)
saitimore,	of Hea of Hea fitem or othe					Location - City or Town, State
ׅׅׅׅׅׅׅׅׅ֟֝֟֝֟֝֟֝֟֝֟֝֟֝	it. Pag irtment irtant: njury o			Hill Cem. 10-30		en_Burnie, MD
מ	Depa Impo any i		21. Signature of current services	1201 Dundalk Ave	zorowski . Baltin	Funeral Home, PA
			23a. Part1. Enter the disease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	r respiratory arrest,	Approximate Interval Between
F	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of the conseque	valual Million	vhage	Onset and Death
E	Examiner		cove by	al aller you	U	16 days
1/	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	rf):		
) O	cate be executed physician and the burial-transit		that initiated events c. Due to (or as a consequence of	f):		
98700,		dical	d			
XO	anding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of delivery
	octificate has been signed by the attending rector, page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □ Ectopic pregnancy 5 □ Other (specify)		Month Day Year
, i	ned by detac		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ecords,	equires en sign ould be	ted by			1 □ Yes	2☐No 3☐ Probably 4☐Unknown
20 8	has be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
الاطار	tificate or, pag	e Co	25. Was case referred to medical	00 Pierra (Death	performed? 1□ Yes 2□1	
	his cer	To B	examiner? 1 □ Yes 2☑ No	26. Place of Death  patient 3 □ DOA Other: 4 □ Nursing Hor		6 □Other (Specify)
	After t			ime of 28c. Injury at 2 jury Work?	28d. Describe how in	
VISIV	ector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home, far	M 1 ☐ Yes 2 ☐ No m, street, factory, office	8f. Location (Street	and Number or Rural Route Number,
5 }	ars afte		Editing, etc. (openly)		City or Town, Sta	_
d Hoer	within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) (Check	death occurred at the time, date and place, a l/or investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
, C	To th COMP	Me	29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
	7	-		dulg DS6349	00	T. 26, 2007 Nere
	4		30. Name and address of person who completed cause of death (Item 23a) (1	301 ST. Paul ST	Balt	nere
	Sta Registra		31. Date filed (Month, Day, Year) 22. Registrar's Signature			
	-51011		U LOUI A ROUGH ST	3462		

Denny Augustus Young State of Maryland / Department of Health and Mental Hygiene 1- For State 2007 347 Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day October 20, 2007 Medical Examiner 1845 hrs DENNY **AUGUSTUS** YOUNG 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1935 Sunberry Road Dundalk Baltimore County 5. Social Security Number If Under 1 Year **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Months Davs Foreian Hours 459-72-8783 1 X M 2 F 63 Yrs 03/11/1944 Country) TX Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show , or items 23a or 28a-f shor must be notified at once 1 Yes 2 MD BALTIMORE DUNDALK Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1935 SUNBERRY ROAD USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? ( Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 1 X Yes Widowed Divorced or other traumatic event, the Medical Examiner Yes, Give Year "natural" Yes 2 X No specify: þ WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hou
Department of Health and Mental Hygiene.
Important: If item 27 is marked 2.1. during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) LABORER MARTIN MARRIETTA 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be SAMUEL YOUNG JENNING DAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN YOUNG/WIFE 1935 SUNBERRY ROAD DUNDALK. MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) Burial 2 XCremation 3 Removal from State **METRO** 11/5/2007 BALTO., MD 4 Donation 5 Other Specify: 21/ Signature of Funeral Service Licens 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. Uton 1701-31 LAURENS ST. BALTIMORE, MD 23al/Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line. /Medical Between Onset and Death Immediate Cause (Final disease a Seizure Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease of Injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. and transit Physician/Medical X UNPENDED burial -#23a,27 28a-f. perME\_G875\_ 1/3/0g TT Box 68760, ned by the attending phydetached for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? has been signed b Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? page certificate ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical Be 26.Place of Death (Check only one) examiner? Other 4 Hospital: this Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 1 V Yes Residence 6 🗸 Other: Scene 28a. Date of Injury (Month, Day,Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural subject hit pole, while playing 5 Pending To the Funeral Director: completely filled in by the Yes 2 Fnd 10/20/2007 Fnd 6:30 pm 2 X Accident Investigation basketball 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State)
1935 Sunberry Rd. Dundalk, MD determined (Specify) Homicide other-scene 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 101 O.C.M.E. October 21, 2007 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 0C 13 0 egistrar's Signatur State 2007 Registra OCME

DHMH 17 Rev 1/2001 **OCME 2006** 

Phys /Me Exar

Division or Vital Records, P.O. Box 68760,

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Marylar	-	artment of H rtificate of I			iene 9g. No. 2 () ()	7 34772
Physicia		Decedent's Name (First, Middle, Las     NEIL	HARVEY		ZIMMERM	AN	2. Date of Deat OCTOBER	26 2007	3. Time of Death 11:29P M
/Medic Examin		4a. Facility Name (If not institution, give	e street and number)	-	4b. City, Town, or BALTIMO	r Location of Death	1	4c. County of De	N/A
Funeral Director		5. Social Security Number 6. S		i. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/01/1	Year) 1954	irthplace (State or Foreign Country) MD
Alasya vita vita (1)	_	Usual Residence of Decedent  10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
th the Ma or 28a-f	Funeral Director	MD N/A  10e. Street and Number	В	BALTIMOF	10f. Zip Code		1	0g. Citizen of What	-
eath wi ns 23a must b	eral	3419 LUDGATE RO	12. Was Decedent Ever in U	U.S. 13. \	Was Decedent of H If Yes, specify Cuba	1215 lispanic Origin? (S	pecify Yes or No-	14. Race - Ar	nerican Indian,
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show is marked other than "natural", or liems 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 🗖 No	an, Mexican, Puer  Specify:		Black, W Specify:	WHITE
n 72 ho i "natur ledical l	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo		16b. Kind of Busines	ss/Industry
ed withi /giene. er than ., the M	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)		CLERK	40.14 II I N	(F) (A 6) dil (A	EDMAR*	T DELI
d be file ental Hy ced oth c event	Be	17. Father's Name ( <i>First, Middle, Last</i> ) <b>HARRY</b>		IMMERMA	N/	GLORIA	ne (First, Middle, I		BUTLER
permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any Injury or other traumatic event, the Medical any Injury or other traumatic	To	19a. Informant's Name/Relationship (			-			, City or Town, State	
1 and Health Iem 27 other tr		GLORIA ZIMMERMAN  20a. Method of Disposition		Place of Dispo	9 LUDGATE	i		MD 212.	
Pages ment of ant: If if ury or o		1  Bunal 2  □ Cremation 3  □ 4  □ Donation 5  □ Other (Specif	Removal from State	ODMOOR.	VONTEETOR HEBREW C	0NG.10/2	8/2007	BALTIMORI	E, MD
permit. Departi Import any Inj once.		21. Signature of Juneral Service Licer	isee Willia		2. Name and Addre			SON & BRO: PIKESVILL	
Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the dea one cause on each line.	ath. Do not ent	ter the mode of dyir	ng, such as cardia			Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	ac Ame	مالح			
ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conse	equence of):	Kio mojo je	as in the			
cate be executed physician and the burial-transit	al Examiner	that initiated events 'resulting in death) Last	C Due to (or as a conse	equence of):					
tificate ig physi as the	<b>l</b> edical		_ d				-		
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after cleath.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf preging the preging of the pregnant at time of god unknown	etal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of Month	delivery Day Year
v requires that the de been signed by the should be detached	þ	Part II. Other significant conditions of	contributing to death but not re	esulting in the u	inderlying cause giv	ven in Part I.	23e. Did to		e to the cause of death?  Probably 4 Unknown
rhe law requir te has been si age 2 should	Completed						24a. Was a autop: perfor	sy prior med? deat	e autopsy findings available to completion of cause of 1? res 2 \sum No
slcian: The la certificate ha irector, page 2	Be C	25. Was case referred to medical examiner?	Hospital		oti poa Oti		ath (Check only or	ne)	
iding Physician: th. : After this certifica ; funeral director, p	ion: To	1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpaties 28b. Time o Injury	of 28c. Inju	4 LI Nursing		ence 6 □Other (5 ow injury occurred	Specify)
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e Place of injury - At	home, farm, sti cify)			28f. Location (S City or Tow		r Rural Route Number,
Hospita 24 hours Funeral tely fillec	Medical C	29a. Certifier Check only one)	nysician: To the best of my ki miner: On the basis of examinand manner stated.	nowledge, deal	th occurred at the to	ime, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
To the within 2 To the comple	Med	29b. Signature and title of certifier	Cardiola	ig ist	29c. Licen:	se number		29d. Date signed (M	ionth, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									

State Registrar

Povesh 31. Date filed (Month, Day, Year)

OCT3 0

THE Rd, Just 533 Kalt, MD 21208

				artment of Health and M rtificate of Death	Reg. f	7 11 11 1	34773
I	Physici		1. Decedent's Name (First, Middle, Last)  Isaac Arokiasamy		2. Date of Death Month  Oct. 8, 20	Day Yeer	3. Time of Death 11:33
	/Medio Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
			116 Staton Drive	Upper Marlboro		rince Geo	
ı	Funeral Director		5. Social Security Number  353 34 1871  6. Sex 1 🛣 M 2 🗆 F  83 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 1 / 30 / 1	ar) Cor	nplace (State or Foreign untry) India
	w w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L.	ocation			10d. Inside City Limits
	Maryl -f sho	tor	D.C. Washing	ton, D.C.		:	1 ☐ Yes 2X No
	or 28a	irec	10e. Street and Number	10f. Zip Code 20017	10g. (	Citizen of What Co	untry?
	ath wi	rai	3733 12th St.,N.E.			USA	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show spiringry or other traumatic event, the Medical Examinant must be maillist at ODCe.	by Funeral Director	11. Marital Status  1	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: AS1	e, etc.
Maryland 21215-0036	within 72 ho ane. Ihsn "natur in Medical I	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of work DO NOT use retired) Selor	ing	Kind of Business/	
5 0	Hygie Hygie other	ဝိ	12 years 5 years Coun  17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		menc
/lan	wild be Mental arked c	To Be	Arokiasamy	Lourduma	ıry		
Nan	ind 2 sho eith and 27 is mu			ng Address <i>(Street and Number or Rura</i> Staton Dr. Upper M			lip Code)
Baltimore,	ages 1 ant of Herminit of Herminit		20a. Method of Disposition  1 \overline{\Omega} \text{ Burial } 2 \overline{\text{ Cremation}} \text{ 3 \overline{\text{ Removal from State}}} align*	osition (Name of matory or other place)  Heaven Cem. 10/13		Location - City or	
altin	mit. P. partme portant y injury		21 Signature of Funeral Service Ucensee 2	2. Name and Address of Facility ${ m JOH}$	IN T. RHIN	ES FUNERA	L HOME
<u> </u>	98 E 2 8		Jan Mary	015 12th ST., N.E.		, D.C. 20	
	Physician /Medical		234. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		or respiratory arrest,		Approximate Interval Between Onset and Death
I	Examiner		Due to (or as a consequence of):				
	d d ansit	Examiner	Sequentially list conditions, if any, leading to immodule cause. Enter Underlying Cause (Disease or injury that initiated events				
,092	ate be executed hysicien and the burial-transit	Ical Exa	resulting in death) Last  Due to (or as a consequence of):				
687	ificate g phys		0.			. 1	
.О. Вох	The law requires that the death certificate be executed tte has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	ivery Day Year
<u> </u>	w requires that I been signed by should be deta	Ď	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacc	_	the cause of death?
Division of Vital Records,		Completed			24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
<u> </u>	ricien: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Deatl	h (Check only one)		RELATIVES
ō	<u>ਦ</u> ਦੁਫ਼	2:	27. Manner of Death 28a. Date of Injury 28b. Time of	nt 3 DOA 4 Nursing Ho of 28c, Injury at Work?	me 5 Residence 28d. Describe how in	6 Other (Specially occurred	RELATIVES RESIDENCE.
ion	Attending Physicien: or death. ector: After this certification in the funeral director, is	atlor	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Divis	i or Atten after deat Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	Hospita 4 hours Funeral ely fillec	edicai C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, evestigation, in my opinion, death occurr	and due to the cause red at the time, date	e(s) and manner as and place, and due	stated, to the cause(s)
	To the To the To the Complet	Med	29b. Signature and little of certifier	29c. License number	29d.	Date signed (Monta	h, Day, Year)
)	(4)		Ind ) hot mo	N0057579	Oc	tober 12,	2077
	Clin		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)		-	, , , , , , , , , , , , , , , , , , , ,
	200		31. Date filed (Month, Day, Year)  32. Registrar's Signature	ST ARUNGTON, VA	1 29902		
	Sta Registr		OCT 1 5 2007 Frencis & South				

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

١.				1 - For Amended 1 Registrar		WCHD,	item#	rifficate of	Death				<sup>e</sup> 200	7	34775
	PI	nysici	an	Decedent's Name (First, Middle						2	Date of Do Month	Da	ay Y	ear	3. Time of Death
	: 	Medic	al	Mary Cathren A				I			10	13			14:50 PM
	E	xamin	er	4a. Pacility Name (If not institutio	1 /// 1	10	tex	4b. City, Town,		Death		40	County of		
	F			5. Social Security Number			ast birthday)	If Under 1 Year	If Under 24	4 Hrs. 8	Date of Bi	rth C	Vicai		lace (State or Foreign
		neral ector		228-18-2883 Usual Residence of Decedent	1 🗆 M 2 🕅 E	35	Yrs.	Months Days		Min.	an 06	ay, Year	)	Coun	try)
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural" or items 23s or 28st show	dical Examiner must be notified at	_	10a. State 10b. County		10c. City	, Town or Lo	ocation						11	0d. Inside City Limits
	le Me	tifle	cto		cester	W	haleyv	ille							1 ☐ Yes 2 ☐ No
	vith th	pe no	<b>Funeral Director</b>	10e. Street and Number 11837				10f. Zip Code				10g. Ci	tizen of Wha	at Coun	try?
	e 23	nust	sral	1837 Steam Mill			- 11-	2187					US.		
	ter de	ner	'n	11. Marital Status	12. Was Decedent Armed Forces?		5. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origii ban, Mexican, I	n? (Specif Puerto Ric	y Yes or No can, etc.)	0-	<ol> <li>Race - Black,</li> </ol>	White,	
35	rs af	xami	by F	1 ☐ Never Married 2 ☐ Married 2 ☐ Married 2 ☐ Midowed 4 ☐ Divorced	If Yes, Give	40		1 □ Yes 2√2 No	Specify:				Specify:	Blac	k
0	2 hou	calE	led	15. Deceden	t's Education		16a. Dece	dent's Usual Occu	pation			16b. K	Cind of Busir	ness/Ind	lustry
21.6	hin 7		ple	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4or 5	i+)	(Give life.	kind of work done DO NOT use retire	during most o ed)	of working					
94	d with	event, the Medical	Completed	8	Ourse (1 is it			Diet	ician				Unive:	rsit	У
þú	al Hy	vent	Be (	17. Father's Name (First, Middle,	Last)				18. Mother's	s Name (F	irst, Middle	e, Maider	n Surname)		
2	Meni	atice	2	Benjamin Harris	son				Bessi	_					
2	2 sh	an		19a. Informant's Name/Relations				ng Address (Stree							
2	and lealth	hert		Virgil O. Armst	rong/husband				Mill Hi					<u> </u>	MD 21872
2	Pages 1 Tent of F	or ot		20a. Method of Disposition 1	∃Removal from State	C	emetery, crei	sition (Name of natory or other pla	· · · · · · · · · · · · · · · · · · ·	Date		20c. L	ocation - Cit	y or To	wn, State
<u>.</u>	Pa tmen	juny		4 □ Donation 5 □ Other (S		Pul:		UMC Ceme		)/20/	2007	Wha	leyvi	lle,	MD
Baltimore Maryland 21215-0036	permit. Departr	any injury or other traumatic event, the M		21. Signature of Euneral Service	Valson		$\mid \mathbf{L}$	2. Name and Addre EWis N. 1 619 Wost	Watson				21.001		
	30	63		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused	the death	. Do not ent	<b>618 West</b> er the mode of dyi	ing, such as ca	ardiac or re	espiratory a	arrest,	21001		Approximate Interval Between
	Physi	cian		Immediate Cause (Final disease or condition	Bran		1	o se temo	W 2						Onset and Death
	/Med	lical		resulting in death)	Due to (or as		- 41	SMIOLME	9					٠.	
	Exam	iner		Sequentially list conditions	b									_   <i>l</i>	1000
(2)	P.	÷	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of):							- 1	
32	ificate be executed a physician and	s the burial-transit	cam	Cause (Disease or injury that initiated events resulting in death) Last	c										
7 8	be ex	ourial		Total in John Jane	Due to (or as	a consequ	ience ot):								
8-18-	cate	the	edical		d									-	
3276 30 x 60	Έ 🖽	70.0		IF FEMALE:	23c. If yes, outcome	of pregnar	ncv								
7 8	requires that the death cert een signed by the attendin	for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic pregnanc Other <i>(specify)</i>	ey .				23d. Date o Month		ry Day Year
20	the d	ched	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	time of de	,aiii 5_	Journel (apecily) _							
4 ª	that	deta	占	Part II. Other significant condition	ons contributing to death be	ut not resu	Iting in the ur	nderlying cause give	ven in Part I.		23e. Did	tobacco	use contribu	ite to th	e cause of death?
armon	quires	rector, page 2 should be detached	d by					_			1 🗆	Yes 2	. □ No 3[	☐ Proba	ably 4 Onknown
7 8	iw rec	shou	Completed								24a. Was	an	24h We	re autor	osy findings available
	The law	age 2	шc		<u> </u>			<del></del>			auto perfe	psy ormed?_	prio dea	r to con th?	npletion of cause of
7. 2	an: ]	tor, p		25. Was case referred to medical					26. Place of	f Death (C	1□ Yes	2 No	0	Yes	2 □ No
30	ysici	direct	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	nt 2∏E	ER/Outpatien	t 3 DOA Oth					6 □Other	(Spanify	
90	ig Ph	Jerai	L L	27. Manner of Death	28a. Date of Inju	ry	28b. Time of Injury						ry occurred	Specify	/
$\mathcal{M}$ Division	ath. or: Af	in efui	Certification:	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investig	ation	( (Car)	Hijary		Yes 2 No	,					
\ <u>\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ </u>	r Atte er de recte	ph t	tific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ				eet, factory, office		28f.	Location (	Street ar	nd Number	or Rural	Route Number,
	ital o irs a ral Di	led	Cer							4					
	To the Hospital or Attending Physician: The I within 24 hours a er death. To the Funeral Director: After his certificate he	letely fil	edical	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the best of Examiner: On the basis of and manner sta	examinati	vledge, death ion and/or in	occurred at the ti restigation, in my	ime, date and popinion, death	place, and occurred	due to the at the time,	cause(s , date an	and mann d place, and	er as sta d due to	ated. the cause(s)
	To the Nithin	сошр	¥e	29b. Signature and title of certifie				29c. Licens				29d. Da	te signed (//	Month, L	Day, Year)
	1	-		2011/				1100	5773	4		10	15/0	7	
	JE.	u	1	30. Name and address of person	who completed cause of de	eath (Item	23a) (Type, I	Print)		,		, ,	1 1 1		
_	U			Michael Felde	, D.O. 100	DE.	CARLOI	1 4. 5	alishury	, me	2				
	Re	Stat gistra		Michael Felde 31. Date filed (Month, Day, Year) OCT 1	7 2007 32. gistra	ar's Signat	ure	and o					-		
							-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Antlfinger Joanne P. 2007 15 Octobe /Medical 4c. County of Death 4b. City, Town, or Location of Death Pacility Name (If not institution, give street and number) Examiner Nicemico enter aksbure eninsula lona Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days Hours 1 M 2 X 288-12-7032 **Director** 8/31/1922 85 Ohio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Oppatiment of Health and Martial Hygiens. Important: If Hear 21 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Me-trail Examiner must be notified at 1 Yes 2 No Ohio Lorain Avon Lake 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 156 Berkshire Road 44012 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: white ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Quinn Anna Burns ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann E. Antlfinger / daughter 7630 Pasadena Ave., Omaha, NE 68124 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St.Joseph Cemetery 10/20/07 Avon, OH 21. Signature of Funeral Service ce 22. Name and Address of Facility
HOLLOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 KELFE. 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ohs trut Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1□ 2 🗷 No 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner The law requires that the death certificate be executed

28a-f show

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

or Attending Physician:

Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than '

ending physician and use as the burial-transit attending p for use as been signed by the a certificate has birector, page 2 s After

Medical Certification: To Be To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the full

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

29a. Certifie

(Check only one)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29h Signature and little of certifier

40059368

29d. Date signed (Month, Day, Year)

omplet d cause of death (Item 23a) (Type, Print) address of derson who

Salish yry MD 100 E. Carroll

State Registrar

ollh 32. Begistrar's Signature 31. Date filed (Month, Day,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 05, 2007 8:03 A October MIGUEL BURGOS 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) PRINCE **GEORGES** CLINTON HOSPITAL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday 1 M 2 □ F El Salvador May 18, 1910 97 10c. City, Town or Location 10b. County Temple Hills 10g. Citizen of What Country? 10f. Zip Code

3 Registrar For State Registrar

**Physician** 

/Medical

Examiner SOUTHERN MARYLAND Birthplace (State or Foreign Country) Social Security Number **Funeral** 215-11-0367 Usual Residence of Decedent Director 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Me thal Examiner must be notified at 1 Yes 2 No Directo Maryland Prince Georges death with the 10e. Street and Number United States 20748 6424 Glen Oak Drive Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Pages 1 and 2 should be filed within 72 hours after a nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or iter 1 ☐ Never Married 2 Married Specify: Hispanic 1 X Yes 2 □ No Baltimore, Maryland 21215-0036 2 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Constructor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicolas Ruano Soledad Burgos ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ana E. Valencia/Daughter 6424 Glen Oak Drive, Temple Hills, MD 20748 Department of Health Important: If item 27 any Injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Silver Spring, MD 20901 Gate of Heaven 10/8/07 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 5538 Marlboro Pike, Forestville, Maryland 20747 Charles É 23a. Part1. Enter the disease, or complications that cause of e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each tip. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to ( as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 4 ☐ Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No certificate has 1∐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Nnpatient 2 ER/Outpatient 3□ DOA Certification: To After this 28c. Injury at Work? 28d. Describe how injury occurred in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2019 becal 32. Registrar's Signature State

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death October 4, 2007 **Physician** Virginia Elaine Bush 9:10p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 127 Jewell Road Dunkirk Calvert | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) | Washington, D.C. 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1□M 2ĂF 579-50-2978 70 Director Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural," or items 23a or 28a-f shov ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Prince Georges Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4520 Lord's Landing #509 20772 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █XNo Specify: Black þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant P.G. County Gov't 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Floyd Brown Sally O. Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau 127 Jewell Rd. Dunkirk, Md. 20754 Rodney Harvey / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 Burial 2 □ Cremation 3 □ Removal from State Arlington, Va. 4 ☐ Donation 5 ☐ Other (Specify) Nov.6,2007 Arlington National 21. Signature of Funeral Servi Licensee Pope Pikė/Forėstville, Md. 20747 M01083 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cau Final disease or condition resulting in death) **Physician** Pul monus Respirat /Medical Examiner Can ( Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (un as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): physician a s the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed?
Yes 2 No rector, page 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Hother (Specify) Son's Resid. 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA ပ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After t Certification: Injury 1 Matural 5 Pending 1 🗋 Yes 2 □ No 2 Accident investigation hours af er death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral Completely filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 9, 2007 025407 v. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  $\,\,$  Internal  $\,$  Medicine  $\,$  Clinic/SGOMI  $\,$ 13/ Elizabeth D. Stewart, Maj. USAF, MC Staff Internist Andrews AFB, MD 20762 32. Registrar's Signature State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 = For State Registrar		rtificate of	Death		neg. No. 200	7 34779				
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Robert W. Boward				2. Date of Dea Month	Day Yea	_ 500/AM				
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of De					
	4		Washington County Hospital		Hagersto			Washing					
	Funeral Director		214-09-1106	yrs. last birthday)  8 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day 4/19/19	7 Year) 9. E M	Birthplace (State or Foreign Country Land				
	and		Usual Residence of Decedent           10a. State         10b. County         10c	c. City, Town or Lo	ocation				10d. Inside City Limits				
	Maryi -f sho	to	Maryland Washington S	mithsbur	σ				1 ∐Yes 2√∑No				
	n 1888	irec	10e. Street and Number	z ciibbai	10f. Zip Code			10g. Citizen of What	Country?				
	23a c ust be	Funeral Director	12021 Steven Ave.		2178	33		USA					
21215-0036	tems	nue	11. Marital Status  12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.				
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	b	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1□Yes ŽŪNo	Specify:		Specify:	White				
5	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	nation during most of work	king	16b. Kind of Busines	ss/Industry				
121	withir ene. than he Me	E C	Elementary/Secondary (0-12) College (1-4or 5+)		intendant		İ	United S	tates Governme				
Maryland 2	filed Hygi other ent, tl			17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Surname)				
	Ald be Alenta rked ric ev	To Be	William Henry Boward			Emma Cr	unkletor	Shindle					
	should wand &		19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street			er, City or Town, State	e, Zip Code)				
	and 2 ealth n 27 i	-	Charlotte Marie Boward/wife		Steven A								
Baltimore,	0 0				osition (Name of matory or other pla en Cemete		Date 6/2007	20c. Location - City  Hagerstow	·				
Balti	permit. Pag Department Important: It any Injury o		21. Signature of Funeral Service Licensee					Funeral (					
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications a caused the shock, or heart failure. List only one cause a each line.						Approximate Interval Between				
			Immediate Cause (Final disease or condition		Onset and Death								
1			resulting in death)  Due to (or as a continuous death)	nsequence of):			0.0						
		-	Sequentially list conditions, b. Due to (or as a co	Due to (or as a consequence of):									
	ted nsit	Examiner	min	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ry Dy	tern	D:54	ask				
,	execu n and ial-tra	Exar	that initiated events resulting in death) Last C	nsequence of):		+ +	7 (7 "	ng Dise	ļ				
68760,	tificate be executed ig physician and as the burial-transit			dC	hasnic	065	Lucy	15 F1.	ng Dise	200			
	rtifica ng ph as th	Medical	IF FEMALE:										
.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/I	by Physician/I	by Physician/I	by Physician/I	by	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf properties of the pregnant at time of the preg	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of o	delivery Day Year
Records, P.	luires that r signed by						by	by	Part II. Other significant conditions contributing to death but no	t resulting in the u	ınderlying cause giv	ven in Part I.	
Ö	aw requires s been si s should b	Completed					24a. Was		autopsy findings available				
æ	The lay cate has page 2	E O					autop perfo	rmed? death					
Vital		Be C	25. Was case referred to medical examiner?			26. Place of Dea		-	65 2010				
or V	hysic his ce I direc	To	1 Yes 2 Hospital: 1 Impatient	2 ER/Outpatier	III OLI DOA		ome 5 Resid	lence 6 □Other (S	pecify)				
n	Attending Physician: r death. ector: After this certifics by the funeral director, I		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Yes	ar) 28b. Time o	Wor		28d. Describe h	low injury occurred					
isio	Attend death. ctor: / y the f	cati	2 Accident investigation 3 Suicide 6 Could not be	At home farm et		Yes 2 No	29f Logation /6	Street and Alumber or	Rum I Pouto Number				
Division	tal or A s after of al Direct ed in by	Certification	4 Homicide determined 200. Place of injury building, etc. (S	pecify)	reet, lactory, office		City or Tow	in, State)	Rural Route Number,				
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my one)  2 Medical Examiner: On the basis of examiner and manner stated.	y knowledge, deat mination and/or in	th occurred at the tinvestigation, in my	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and manner date and place, and d	as stated. due to the cause(s)				
	To the withing To the COTE	Me	29b. Signature and title of certifier	4	29c. Licens			29d. Date signed (Mo	onth, Day, Year)				
			Jane muste		1)0(	50396		10/14/	0 (				
			30. Name and address of person who completed cause of death	AED.	117	Hage	pal	ctmp	21740				
1	Sta Registi		31. Date filed (Month, Day, Year) 8 2007 32. Ryistrar's 8	Signature	brisk	Harden	, (	,					

	•	1.01	epartment of Health and N Certificate of Death	Mental Hygiene	007 34780			
Physic		1. Decedent's Name (First, Middle, Last)  Richard Sutton Buck IV		2. Date of Death Month 10/10/20	07 Year 3. Time of Death 2201 M			
/Medi Exami		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis		County of Death ne Arunde1			
Funeral Director		5. Social Security Number 226-38-7287 6. Sex 1 → 7. Age (In yrs. last birtho. 75 Yrs.	Months Dave Hours Min	8. Date of Birth (Month, Dey, Year) 4/26/1932	9. Birthplace (State or Foreign Country) Virginia			
Aaryland	or	Usual Residence of Decedent  10a. State			10d. Inside City Limits 1 □ Yes 🏖 🛣 No			
with the has or 28a-	Director	10e. Street and Number 5789 Greenock Rd.	10f. Zip Code 20711	10g. Citiz	zen of What Country? USA			
DESILITIOTE; INTELYIGITION A.I.A. IO-DUOO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinar must be notified at any Injury or other traumatic.	by Funeral	11. Marital Status  1 Never Married 2X Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 X Yes 2 No If Yes, Giv 7 i etnam Year or Dates.	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto     □ Yes 2 ☑ No Specify:	Rican, etc.)	4. Race - American Indian, Black, White, etc. Specify: White			
I Z I 3-UU30 vithin 72 hours af ne. han "natural", or nedical Exam	Completed t	15. Decedent's Education (Specify only highest grade completed) (College (1-4or 5+)	ecedent's Usual Occupation live kind of work done during most of work fe. DO NOT use retired)	ring	nd of Business/Industry			
riand Z	To Be Cor	17. Father's Name (First, Middle, Last) Richard S. Buck Jr.		La e (First, Middle, Maiden Pitkin				
, INGLY and 2 shotalth and h 27 le ma er trauma			failing Address (Street and Number or Run  Greenock Rd. Lot	al Route Number, City or				
DAILIMOTE  Dermit. Pages 1 a  Department of He mportant: If item iny Injury or oth		20a. Method of Disposition  1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State	isposition (Name of crematory or other place)	Date 20c. Loc	cation - City or Town, State			
Danit. Departininporta		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Har 12 Ridgely Ave. Ann		- 167 SORO - 13 Lt 18979			
Physician		23a. Part1. Enter the disertie, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	enter the mode of dying, such as cardiac Pneumonia.	or respiratory arrest,	Approximate Interval Between Onset and Death			
/Medical Examiner		resulting in death)  Due to (or as a consequence of)  Sequentially list conditions,  b.	:					
certificate be executed dring physician and use as the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):						
death certifi death certifi e attending d for use as	hyslclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	2	23d. Date of delivery Month Day Year			
ords, F.C. requires that the een signed by the nould be detached.	by P	Part II. Other significant conditions contributing to death but not resulting in the weeks fafic lung cancer	ne underlying cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death?			
The tay ate has page 2	Completed	acute renal failure.		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No			
OI VICE Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1	atient 3 DOA Other: 4 Nursing Ho	h (Check only one) ome 5 Residence 6 28d. Describe how injury				
or Atten	Certification;	Natural   5   Pending   (Montm, Day Year)   Injury	d Number or Rural Route Number,					
In the Hospital within 24 hours a To the Funeral Completely filled	dical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, continuous of my knowledge, continuous on the basis of examination and/continuous of my knowledge, continuous of	feath occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the cause(s) red at the time, date and	and manner as stated, place, and due to the cause(s)			
to the comp	Me	29b. Signature and title of certifier	29c. License number $D585(0)$	ł	e signed (Month, Day, Year)			
OF COR		30. Name a address of erson who complete cause of death (Item 23a) (Ty  Stephen Olexo AA)	NC.		,			
St Regist	ate trar	31. Date filod (Month, Day, Year)  OCT 1 5 2007  32. Registrar's Signature	Sperte					

MODELO

**Physician** /Medical Examiner Immediate Cause (Final disease or condition resulting in death)

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othe any injury or other traumatic event, page.

**Funeral** 

Director

7 is marked other then "naturel", or iteme 23a or 28a-f ahow traumatic event, the Macincal Examinar must be ristilled at

death with the Maryland

filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0036

physicien and s the burial-transit

Physician/Medical ģ Completed

To the Hospital or Attending Physicien: The law requires that the death certificate be executed

this

Director:

within 24 hours a To the Funerei

Division of Vital Records, P.O. Box 68760,

	mousto Tio west closs Sc.	Gaicha, Ind. 21033
Partt. Enter the disease, or shock, or heart failure. List	complications that caused the death. Do not enter the mode of dying, such as cardiac or respir only one cause on each fine.	Interval Between
ediate Cause (Final use or condition ting in death)	a. Respiratory failure  Due to (or as a consequence of):	Onset and Death 5 day 5
entially list conditions, , leading to immediate e. Enter Underlying e (Disease or injury nitiated events	b. End Stage Chronic Obstructive Pulmon. Due to (or as a consequence of):	avy Discose years
ing in death) Last	Due to (or as a consequence of):  d	
MALE: Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Covorary Artery Discoss Afiby Gout, BPH, 1 Yes 2 No 3 Probably 4 Unknown Hx Ischonic Colitis. 1 chol, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 24 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death Check only one Hospitaf: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 2 Accident investigation 1 Tyes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0050996

State Registrar

DHMH 17 Rev 1/2001

OCT 1 6 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Neil Stoddard, M.D. 100 Brown St. Chestertown, MD. 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 /Medical 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Spital 6. Sex 1 ☑ M 2 ☐ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 212-34-4569 71 01/21/36 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 1 X Yes 2 □ No Director MD Kent Chestertown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 104 Conley Dr. 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White þ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Highway Worker Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental H Be Thomas Rodney Baxter Mary Lafferty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Taylor/Daughter-in-Law 104 Conley Dr. Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 and Depertment of He 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Chester Cemetery 10/9/07 Chestertown, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility  ${\sf Fellows}$  ,  ${\sf Helfenbein} \& {\sf Newnam}$ Kuk 9 130 Speer Rd. Chestertown, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Premonary Awast. 12hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Artero Sclovotic Condio Vescular Discose Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Exami sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy for Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Ti Inknown certificate has been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DM Type II, CKD, GERD, HH, 3 Probably 4 □Unknown 1 🗌 Yes 2 🗌 No Completed PChola Chronic Edema 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 242 No 1□ Yes e Hospital or Attending Physician: 24 hours after death. e Funeral Director; After this certifica director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

12

100 Brown

32. Regis

Chestertown MD 21620

State of Maryland / Department of Health and Mental Hygieng For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 16:52 P.M Audrey Mae Burke 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nicomico REGINAL MEDICAL Salisburg HAINSULA If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** Months 1 ☐ M 2 🖾 F 214-32-0775 Jan. 15, 1936 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director Wicomico Fruitland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō fited within 72 hours after death with items 23a 405 West Main Street 21826 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No 1 □ Never Married 2 □ Married 21215-0036 9 1 ☐ Yes 2 No Specify: Specify: white 3 X Widowed 4 □ Divorced \*natural 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Certified Nursing Assistant 12 land: 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fit Health and Mental H tem 27 is marked oth Be Andrew Thomas Parks Cora Mae Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
important: If item 27 is
any injury or other trau David Burke (Son) 31996 Fooks Road Salisbury, MD 21804 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Crematory of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ďelmarva Delmar, Delaware 10-13-2007 22. Name and Address of Facility
Short Funeral Home
13 E. Grove Street 21. Signature of Funeral Service Licensee Delmar, DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final ASCUD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical ed by the ettending phys detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 Yes director, Be 26. Place of Death Check only one 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 R/Outpatient ٩ 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a

To the Funeral C

completely filled i Medicai 1 ritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier HOO56197 10/12/2007 30. Name and address of Jerson who completed cause of death (Item 23a) (Type, Print) Salishy And 2(80) Robert Coker 400 Ensten shor Drive 32. Registrar's Signature 31. Date filed (Month, Day, Year) 5 Registrar

405W

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Year 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month / D Day 200 **Physician** Albert Jerome Brannan 11 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner / edica Salisbury
If Under 1 Year If Under 24 Hrs. eninsula Regiona Center KIMICO 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Min. Days Hours 1**∑**M 2□ F 217-34-6568 68 9, 1939 Director Jan. Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, th- M. di al Examiner must be notified at 1 X Yes 2 ☐ No Director DE Sussex Delmar 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 101 East Delaware Avenue 19940 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Mayes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 ☐ Never Married 2 ☐ Married 1957-Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3₺Widowed 4 Divorced white 1961 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7, th and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Automobile 10 Automotive Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked ony injury or other traumatic ev ည Peter Brannan May Wonder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas A. Brannan (Son) 11661 Glen Road Bridgeville, DE 19933 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crematory of Delmarya Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 10-13-2007 Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 E. Grove Street Delmar, DE 19940 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. 23a. Part1. Enter the disease shock, or heart falure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASPIRATION PNEUMOMIA /Medical Due to (or as a consequence of): Examiner ASCVD Sequentially list conditions, it ally, leading to infinitely cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CRI be executed burial-trar and Due to (or as a consequence of): physician Physician/Medical the signed by the attending be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DEMEN TIA 1 ☐ Yes 2 ☐ No 3 Probably 4 □ Unknown Completed CVA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1∏ Yes director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, To the Hospital or Attending Ph, within 24 hours after death.

To the Funeral Director: After thing completely filled in by the funeral. Medical

P.O. Box 68760.

State Registrar 29a. Certifier

29b. Signature and title of certifier

104 MILTONO ST.

29c. License number

54/156414, MO

29d. Date signed (Month, Day, Year)

and manner stated.

Registrar's Signature

M.O.

M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		•	For State Registrar	State of Mar	yland		artmen				Re	g. N2. ()	0.7	34785			
E	Physici		1. Decedent's Name (First, Middle, Last, Ronald D. Baker								2. Date of Deat Month	Day	2007	3. Time of Death 2/25 M			
**************************************	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of	f Death	10	/2 4c. Cour	nty of Death				
1	LAAITIII	CI	Peninsyun Region	y Medical	1 16	nter		54	11564	14			Vicom	100			
	Funeral Director		5. Social Security Number 6. Se 216-44-8750		(In yrs. las	t birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min	8. Date of Birth (Month, Day, July 9,	<sup>Year)</sup> 1946		lace (State or Foreign try) vland			
	land		Usual Residence of Decedent  10a. State 10b. County	1	I0c. City,	Town or Lo	cation						1	Od. Inside City Limits			
	Man Hind	tor	DE Sussex		Sea	aford								1 ☐ Yes 2\timesNo			
	or 28	Olre	10e. Street and Number			_	10f. Zip	Code			1	0g. Citizen o	of What Coun	try?			
	s 23a	ra	28900 Johnsons D		in II C	12.1		973		-in 2 /C	aitu Van as Na	U.S.	A. lace - Americ	an Indian			
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23a or 28e-f show other treumatic event, it is Mudical Examinet must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☼ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			was Deced If Yes, spec 1 ☐ Yes	offy Cubar	Specify:	nr (Spe , Puerto F	cify Yes or No- Rican, etc.)		lack, White,				
9-0	2 hou	ted	15. Decedent's Edu	cation			dent's Usua					16b. Kind of	Business/ind	dustry			
21215-0036	ithin 7 18.	Completed	(Specify only highest grad	e completea) College (1-4or 5+)		lite.	kind of wo DO NOT us	se retired)	)	or workir	ig		_				
121	filed with Hygiene. other than		12 17. Father's Name (First, Middle, Last)				Sup	ervi		r'e Namo	(First, Middle, I		lon Co	ompany			
anc	ould be fi Mental P wrked of	Be	Calvin S. Baker								Adkins	naiden sum	ame)				
Maryland	2 should be filed and Mental Hygels marked other reumatic event,	2	19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mailir	ng Address	(Street a			Route Number	City or Tov	vn, State, Zip	Code)			
	1 and 2 : Health ar tem 27 is		Deborah D. Baker	(Wife)		28900	0 Joh	nson	s Dri	ve	Seaford	, DE	19973				
ore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Compared from State	20b. Plac	ce of Dispo	osition (Nan	ne of ther place	в)	D	ate	20c. Locatio	n - City or To	wn, State			
Ë	Pages ment of the ent: If Its ury or of		4 □Donation 5 □Other (Specify)		St. S	Steph	ens C	emet	ery 1	0-16	-2007 I	)elmar	, Dela	aware			
Baltimore,	permit. Pages Department of Importent: If it any injury or once.		21. Signature of Funeral Service Licens Short	- Jewel	L	SI	Name and hort 1	Fune:	ral H	ome	Delma;	c, DE	19940	)			
1760,	Physician /Medical Examiner	Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a b. Due to (or as a c. Due to (or as a	conseque	nce of):	Con	Ce V	·					Onset and Death			
P.O. Box 68	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit		Physician/Med	Physician/Med	Physician/Med	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions co	d	Fetal d	leath 3[ th 5[	□Ectopic pr □ Other (sp	pecify)	en in Part I.		23e. Did tol		Date of delive
Records,	uires (	d by	Huper ton	Sien.				g				es 2□No	/	pably 4 □Unknown			
COL	w requir s been s should	Completed	colon s	Mervi							24a. Was a		b. Were auto	psy findings available			
Re	The la	mo	Liver S	JU18074							autops perfori	ned?	prior to co death? 1 ☐ Yes	mpletion of cause of			
Vital	sien: ertifica ictor, p	BeC	25. Was case referred to medical examiner?	00					26. Place	of Death	Check only or						
of \	hysic this co	ဥ	1 Yes 2 No	Hospital: 1 Inpatient		R/Outpatie			4 📋 Nu		ne 5 Reside			y)			
	ding F h. After funer	tlon	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year)	8b. Time o Injury	M 2	28c. Injury Work	/at <br Yes 2 □		28d. Describe h	w injury oc	curred				
Division	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At hom (Specify)	ne, farm, st					28f. Location (S City or Town		mber or Rura	al Route Number,			
	To the Hospitel or within 24 hours affer to the Funerel Dir completely filled in in	edical C	29a. Certifier 1 Certifying Phy one) 1 Medical Exam	vsician: To the best of iner: On the basis of e and manner state	examinatio	ledge, deat on and/or in	th occurred nvestigation	at the tim	ne, date an pinion, dea	d place, a	and due to the c ed at the time, d	ause(s) and ate and plac	manner as s ce, and due to	tated. o the cause(s)			
	To the To the Complete  Me	29b. Signature and title of certifier	0 0			1	_	number		2		gned (Month,					
	10		D. 19. 1830	Jakell				1700(	F00	12		10/	1919	. Foot			
	Son		)	ompleted cause of dea	ath (Item ;	23a) (Type,	Print)	1,8	desla	wy,	c am	41801					
15 m	Sta Regist		31. Date filed (Month, Day, Year) 5	2007 32. Projestrar	's Signatu	Treat A	frank	1									

amended item 1/10/17/2007/wico. h.d./map Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Gordon David Bates 0517 tones 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns TUSP, Ta) Jatinone Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth Birthplace (State or Foreign Country) **Funeral** Vear Months Days Hours 1 **⊠** M 2 □ F 9/15/1943 64 Director 257-66-4642 Georgia Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10h County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Wicomico Maryland Salisbury 10g. Citizen of What Country? 10e Street and Number 10f Zin Code 408 Forest Lane 21801 USA Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director of Operations Vista Design & Survey 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gordon Lee Bates Lillie Pearl Oneal မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 408 Forest Lane, Salisbury, MD 21801 Myra W. Bates/wife 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Salisbury Crematory 10/16/07 Salisbury, MD 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 David H. CFSP homood 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MMGMag **Physician** 9 Nays /Medical Due to (or as a consequence f): Examiner Negnama Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed trolle and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 ☐ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 P No 1 Tes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 has autopsy 2 No certificate 1□ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 3□ DOA မှ 2 ER/Outpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 5 □ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ca ဂ္ဂ MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wolfe St Baltimore Maryland 21287 olb LOCC 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

7 200

			For State	State of Marylar	•			Mental Hy	giene	9			
			Registrar		Cer	tificate of	Death		Reg. No	2007	34787		
Н	Physici	an	Decedent's Name (First, Middle, Last)		72	1-		2. Date of De Month	eath Da	y Year	3. Time of Death		
	/Medi		4a. Facility Name (If not institution, give stre	et and number)	1220	Ab City Town of	Location of Death	10	14	County of Death	11:49 AM		
-	Examir	ier	Penincula Regiona	1 Medical 1	Penter		bury		1/1	Dica mic	۵		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	D-	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	rth	9. Birth	place (State or Foreign		
	Director		218-20-3413	2□F 80	Yrs.	Months Days	Hours Min.	10/17/			yland		
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or Loc	ation					10d. Inside City Limits		
	Maryl -f sho fied a	to	Delaware Sussex	Se	eaford						1 □Yes 2 🖫 No		
	h the or 28a o notii	irec	10e. Street and Number			10f. Zip Code			10g. Cit	tizen of What Cou	ntry?		
	th wit 23a o 1st be	a D	28718 Ellis Mill R	oad		19973	3			USA			
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at	Funeral Director		Was Decedent Ever in U Armed Forces?	J.S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	D-	14. Race - Americ Black, White,			
36	rs afte	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates: Army	. 1	☐Yes 2X No	Specify:			Specify: W	nite		
9	2 hou atura cal E	Completed by	15. Decedent's Educat	ion	16a. Deced	ent's Usual Occup			16b. K	ind of Business/In	dustry		
218	thin 7 e. an "n Medi	nple	(Specify only highest grade c Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	kind of work done on NOT use retired	during most of wor d)	king	1		unty Solid		
2	lygien Per th	S	11	***	Super	visor				te Depar	tment		
and	iould be fi Mental H narked ott natic even	Be	17. Father's Name (First, Middle, Last)  John Wesley Baker				18. Mother's Nan	E. Down		Surname)			
Maryland 21215-0036	2 should n and Men is marke raumatic	မ	19a. Informant's Name/Relationship (Type.	Print)	19b. Mailin	g Address (Street				or Town, State, Ziu	n Code)		
Baltimore, Ma	s 1 and 2 soft Health are item 27 is		Doris E. Baker/wif		287.	l8 Ellis	Mill Rd.	, Seafc	rd,	DE 19973	1		
	iges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	2			20a. Method of Disposition  1 ☑ Burial 2 □ Cremation 3 □ Ren	20b.	Place of Dispos cemetery, crem	sition (Name of natory or other place Memoria	(e)	Date	20c. Lo	ocation - City or To	own, State
	Pag ment ant: I		4 □ Donation 5 □ Other (Specify)	W:	Park		10/	18/07	Ī	lisbury,			
Ball	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other		21. Signature of Funeral Service Licensee	a CF	SP 22	Name and Addre	Funeral	Home Pr	ofes	sional A	ssociation 04		
	40= 60			tions that raused the dea						7, MD 218	Approximate		
E	Dhusisian		3a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	50 1101 01110	in the mode of dyn	ig, such as outday	or respiratory t	arrost,		Interval Between Onset and Death		
e	Physician /Medical		disease or condition resulting in death)	Due to (or is a conse	quence of):						<u></u>		
	Examiner		Conventially list conditions	Urma		ref	to be	die-					
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con-									
	icate be executed physician and s the burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a conse									
8760,	be exician burial	al E		Due to (or as a conser	quence oi).								
687	ficate p phys s the	edical	d										
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	If yes, outcome pf pregr		Estania programa				23d. Date of deliv	ery		
	e deat ne atte ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of 9☐Unknown		Ectopic pregnancy Other (specify)	/			Month	Day Year		
P.O.	that the de ned by the a detached t	Phy	9 ☐ Unknown  Part II. Other significant conditions contri		oulting in the up	doduine esues siu	on in Doct I	22a Did	tabaaaa		the same of death?		
ds,	w requires that been signed to should be det		Part II. Other significant conditions contri	E	sularly in the un	denying cause giv	en in Part I.		Yes 2	use contribute to t	the cause of death?		
200	v requ been should	Completed by	Conjerne (		2 - (								
Re	he law has l	Id m		<u> </u>				24a. Was auto perf		prior to co	opsy findings available empletion of cause of		
ta	an: T tificate tor, pa		25. Was case referred to medical				26. Place of Dea	1□ Yes	2 No	1 ☐ Yes	2□ No		
<u> </u>	nysici iis cer direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	pital: 1 Inpatient 2	BR/Outpatien	t 3□ DOA Oth	or.			6 ☐Other (Speci	fy)		
0 0	ing Pt ifter th		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe	how inju	ry occurred			
Division or Vital Records,	tendi leath. tor: A the fu	catio	Accident investigation				Yes 2 □ No						
$\leq$	after of Direction by	Certification:	4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Spec		eet, factory, office		281. Location City or To	(Street ar own, State	nd Number or Rur e)	al Route Number,		
	ospital hours uneral		29a. Certifier Certifying Physic	ian: To the best of my kn	owledge, death	occurred at the ti	me, date and place	e, and due to the	e cause(s	s) and manner as	stated.		
	T 4 IL W	Medical	(Check only 2 Medical Examine one)	r: On the basis of examin	ation and/or inv	estigation, in my o	ppinion, death occ	urred at the time	, date an	nd place, and due	to the cause(s)		
	To the I	Σ	29b. Signature and the of certifier			29c. Licens	e number		29d. Da	ate signed (Month,	Day, Year)		
			1/2/	AI)		D	54879		1 -	1/4/0-	7		
1	10		30. The and a tress of person who com	oleted cause of death (Ite	m 23a) (Type, i	Print)	) // -	1 6.1	6				
	Sta	ate	31. Date filed (Month, Day, Year)	Dieted cause of death (Ite	natyre	IUOE. C	arroll Si	· Dalis	Dury	mDo	1801		
	Regist		OCT 1 7 200	Descue.	B A	acti)							
DH	IMH 17 Rev 1/2	001		10									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM 7 per FH C872 10/31/07 WS Mental Hygiene State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year October **Physician Bland** Albert 2007 6:15P James 23 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles Waldorf Gillespie Circle 12119 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

7. Age (In yrs. last birthday) Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F 77 578-36-9930 February 28,1930 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County 10a. State r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Waldorf Charles Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20601 12119 Gillespie Circle Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 9 Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Property Management 12 permit. Pages 1 and 2 should be filed I Department of Health and Mental Hygis Important: If item 27 is marked other I any Injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Isabel Wynn James Bee Bland ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 420 Fairhaven Road, Tracys Landing, MD 20779
e of Disposition (Name of Date 20c. Location - City or Town, State Richard Bland/Brother Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 10/31/07 Suitland, Maryland 4 □ Donation 5 □ Other (Specify) M00945 22. Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, P.A. 21. Signature of Funeral, Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical o (or as a consequence of) Examiner DCOVAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner be executed and burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery use 23b. Was decedent pregnant 3 □ Ectopic pregnancy Year Month Day in the past 12 months? for 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No 1∐ Yes certificate the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 26. Place of Death (Check only one, 25. Was case referred to medical Be Other: 4 Nursing Home Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient P 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 October 24, 2007 D000)923 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Up 008, 8 - 050)d 32. Registrar's Signature 31. Date filed (Month. Dav. Year)

State

30

Registrar

made

			1- For State of Maryland / Dep. Registrar Ce	artment of Health and M rtificate of Death	lental Hygie Reg.	ne 2007	34789
	Physici	an	1. Decedent's Name (First, Middle, Last)  DONALD BROWN COLEMAN SR.		2 Date of Dogth		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Chester River Hospital	4b. City, Town, or Location of Death Chestertown		4c. County of Death	
	Funeral		5. Social Security Number  220-01-5020  6. Sex  1 ☑ M 2□ F  89  Yrs.	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye Sept 2 1	9 Rint	nplace (State or Foreign untry) Laware
	Director		Usual Residence of Decedent  10a. State		pepe 2 1	370 DC	10d. Inside City Limits
	e Maryl Sa-f sho	ctor	MD Kent Chester	ctown			1 ☐ Yes 2 🕱 No
	with th	I Dire	25750 Collins Ave.	10f. Zip Code 21620	_	Citizen of What Co	untry?
36	should be filed within 72 hours after death with the Maryland and Menial Hygiene. marked other then "neturel", or items 23s or 28s-f show imatic event, the Medical Examiner must be matified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	
Maryland 21215-0036	within 72 housne. International International	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation skind of work done during most of work DO NOT use retired)	ing	Construc	
and 2	9 7 2 5	Be	10 Su  17. Father's Name (First, Middle, Last)  Bertie Coleman	perintendent  18. Mother's Name  Etta W	e (First, Middle, Maid		CIOII
aryli	os 1 and 2 should b of Health and Ment item 27 is marked r other traumatic a	٦	19a. Informant's Name/Relationship ( <i>Type, Print</i> ) 19b. Mail	ing Address (Street and Number or Rura	al Route Number, Ci		
	1 and 2 Health em 27 I		Clara Elizabeth Coleman (wife)  20a. Method of Disposition  20b. Place of Disp			estertow Location · City or	
altimore,	Pages nent of I int: If it		Cemetery, cre	matory or other place)		nesterto	
Balt	permit. Page Depertment of Important: If eny Injury or once.		21. Signalum of Funeral Santia Licensee M00510 1	2 Name and Address of Facility alena Funeral H 18 West Cross S	ome of S t. Galer	Stephen na, MD.	L. Schaech 21635
			23a. Paint. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between Inset and Death
H	Physician /Medical Examiner		Immediate Cau (Final disease or condition resulting in dieth)  a. Tue to (o) as a consequence of):	PRUMONIA			15 m12
1	A	Iner	Sacrentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
8760, 5	cate be executed physicien and the burial-transit	dical Examin	Cause (Disease or Injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d				
P.O. Box 68	The law requires that the death certifics wie has been signed by the ettending phage 2 should be detached for use as t	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	ivery Day Year
	w requires that been signed b should be deta	þ	Part Other significant conditions contributing to dealh but not resulting in the	underlying cause given in Part I.	23e. Did tobac	1/	the cause of death?
al Records,	: The law recete has be-	Completed			24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of 2 No
Z Z	ysician s certifi director	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 Vo Hospital: 1 Inpatient 2 □ ER/Outpatie	Other	n <i>(Check only ohe)</i> me 5□ Residence	e 6 ∏Other (Spec	cifv)
Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificete has completely filled in by the funeral director, page 2.	atlon: T	27. Magner of Chath 12 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how i		304)
DIVIS	al or Atte s after des i Directo od in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ıral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Medical Exeminer: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurred	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comp	W	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Monti	h, (fay, Year)
	15		30. I ame and address of person who completed cause of leath (Item 23a) (Type	Print)	to.	MA	
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	A W.	VICE N	, /- (4)	1
	Registr	ar	OCT 3 0 2007	William Stanton			

07-07918 Bruce S. Covington

Me (

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

31,790 2007

e o. oovinge		I- For State Registrar	Ota	01 1	viai yiai		•	cate of			3	, 9.		. No.	200	1 54	100
Physicia		Decedent's Name	(First, Middle,	Last)				• • •					Date of Death Month	Day	Year	3. Time of Death	
ical Examir			STEVEN									C	ctober 10	2007		2359 hrs	
		4a. Facility Name (if Chestnut Ma		-		nber)		4	b. City, To Center		ocation of	Death			unty of Death en Anne's		
						7. Age (In y	us loot b	istbolov()	If Under		If Under	24Hrs 8	Date of Birth			thplace (State or	$\rightarrow$
Funeral Director		5. Social Security No.	500	. Sex		53	/15. last b	Yrs.	Months	_	Hours	Min	12/18/			m MARYLAN	ID
<u>\$</u>		Usual Residence of 10a. State	Decedent 10b. County			110c	City Tow	vn or Locati	on			_				10d. Inside City I	Limits
ow any			QUEEN A	ATATE?	l c			ISTOWN								1 Yes 2 X	₹ No
yland a-f sh	햣	MD 10e. Street and Num	•	MNE	<u> </u>	_ V	UEEN	STOWN	10f. Zip (	Code			100	g. Citizen	of What Cou	ntry?	
the Mai 3a or 28	Director	1214 JO		N R	DAD				2	2165				USA			
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Marrie	d 2 X Mar		. Was Dece Armed Fo Yes						anic Origii Mexican, I		fy Yes or No- an, etc.)	14.	White, etc.	ican Indian, Black,	,
	by F	3 Widowed	4 Divo	ced If Ye	es, Give Year	- (2)			Yes 2							HITE	
ours a		15. Decedent's Ed		fy only h			ed) 16	a. Deceden			on (Give ki			16b. Kind	of Business	Industry	
nore, MD 21215-0036 sages I and 2 should be filed within 72 hours after nt of Health and Mental Flygiene. It: If item 27 is marked other than "natural", other traumatic event, the <u>Medical Examiner</u>	Completed	Elementary/Second 12	ndary (0-12)		College (1-	-4 or 5+)		COMPT						STAT	E OF I	MARYLAND	
5-0 led wi lygie other	Col	17. Father's Name (	First, Middle, L	ast)						1	8.Mother's	Name (Fi	irst, Middle, M	aiden Sur	rname)		
21 be fill ental F urked	Be		A. COV										LEY SPA				
D 21 should and Mer 7 is man	Ţ	19a. Informant's Na					- 1						al Route Num			e, Zip Code)	
MC 2 salth a sm 27 raum:		JACY J.		CON/	DAUG			DIU N					ron, M			r Town, State	-
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 'Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medic.		1 Burial 2	Cremation Other Spe		Removal fro		cren	natory or ot APEAK	her place)		OPV	10–13	-2007	SI	EVENS	VILLE, MI	)
altii mit. partm porta ury o		21 Signature of Fact	Service I	icenses				22. 1	Name and	Address	of Facility			TAM T	ZITATIZD A I	TIONE I	
<b>a</b> 8 2 E E	(	w	Mec	11	n	<u>ٔ ب</u>		40	S S	LIB	ellen Ekta	ST	CENTR	EVILI	E, MD	21617	ntonuol
Physician	failure. List only one cause on each line.											Between Ons Death	Ct attu				
'Medical .xaminer		Immediate Cause (			ad Injuri										_	Death	
		or condition resultir	ig in death)	Due	to (or as a	conseque	nce of):										
	er	Sequentially list cou if any, leading to im		Due	to (or as a	conseque	nce of):							10.			
	min	cause. Enter Unde (Disease or injury to		c	<u>-</u> .											<u> </u>	
760, icate be executed physician and the burial - transit	Examine	events resulting in	death) Last	d	to (or as a	conseque	ence of):										
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours affect death. Finneral Director: After this certificate has been signed by the attending physician and lely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	edical	UNPENDED		A	MENDED												
760, cate be physic the bur	Σ	IF FEMALE:	prognant in the		23c. If yes,	outcome o	f pregnar	ncy							Date of delive	-	
Box 687 he death certific the attending p	Physician/	23b. Was decedent past 12 months			Live b	oirth nant at time	e of death	-	etal death	3	Ectopic	pregnand	СУ	M	onth	Day Ye	ar
Sox leath c e atter for us	sic	1 Yes 2 1	No 9 Unk	2011	9 Unkn		,	¹ 5 _ O	ther (Spe	сіту)							
O. Bhat the ded by the letached			ficant conditi	ons co	ntributing t	o death bu	t not resu	ulting in the	underlying	cause (	given in Pa	rt I.	23e. Did to	bacco us	e contribute	to the cause of dea	ath?
ires that signed	d by								_				1 Yes	2 🗸 1	No 3 Pr	obably 4 Unk	nown
ords, w requir is been s should l	Completed												24a. Was autop			autopsy findings a completion of car	
COP law e has l	μ				-	_								rmed?	death'		No
tal Reco		25. Was case refer	red to medical							26.Place	e of Death	(Check on		2 110		103 2	110
Vital I ysician: his certifi director,	o Be	examiner?		Hos	pital: 1	Inpatient	2 E	R/Outpatier		OOA	Other 4	_	Home 5	Residence	ce 6 🗸 Ott	ner: Scene	
of Vital Records, iing Physician: The law requir After this certificate has been s funeral director, page 2 should I	Ι:	27. Manner of Dea	2 No		28a. Date	of Injury	2	8b. Time of	Injury	28c. Inju	ıry at Work		8d. Describe				
ion tendin eath.	tion	1 Natural	5 Pend		Oct 10,	Day Year) 2007	2	2353 hrs		1	Yes 2 🗸	No D	river auto	auto co	MISION		
Division tal or Attendir rs after death.	fica	2 Accident 3 Suicide		tigation d not be	28e. Plac	ce of Injury	- At hom	ne, farm, stre	et, factory	, office t	building, et	tc. 2	28f. Location ( or Town, \$		Number or	Rural Route Numb	er, City
Division Spital or Attent hours after death meral Director:	Certification	4 Homicide		mined	(Specify)	Major	Road	/ Highwa	у			С	hestnut Mar	nor Farm	Lane & Rt	309, Centerville	e, Md.
the ple	Medical C		Certifying Ph Medical Exa	miner:0	n the basis	of examina	nowledge ation and	, death occi	urred at the ation, in m	e time, d y opinior	late and plan, death oc	ace, and d	ue to the caus the time, date	se(s) and and place	manner as s e, and due to	ated. the cause(s)	
To To	Med	29b. Signature and		ar	nd manner:	stated.					se number			· · · · · ·		Month, Day, Year)	
			na M	Vin	unt.	, m.D				O.C.	M.E.			Octo	ber 11, 20	007	
fp 12		30. Name and add	ress of person	who cor	npleted cau				1 Pont	Strack	+ Baltim	ore Mr	21201	1			
12	L	Donna M. \			ssistant	-			renn	Street	t, Baltim	ore, IVIL			<del></del>		
S Regis	tate tra		OCT 1	5 20	07 <sup>32. R</sup>	Sola Color	Signature	K A	meli	,				_			

State of Maryland / Department of Health and Mental Hygien 2007 34791 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10 Jacqueline 14 2007 0829 Sue Cooper /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 10212 Grapevine Road Mardela Springs Wicomico 5. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖺 F Hours 44 Director 7-20-1963 215-80-2650 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28e-f show any injury or other traumatic event, the Maryland Exercitive Industrial at ODEs. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Directo MD Wicomico <u>Willards</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 35598 Tingle Road 21874 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 3 ☐ Widowed 4 ☑ Divorced ieted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Compi Elementary/Secondary (0-12) College (1-4 or 5+) 12 Certified Nursing Assistant Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jackie Samuel Cooper Patricia Ann Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jackie S. Cooper - father 35598 Tingle Road, Willards, MD 21874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-18-2007 | Pittsville, Maryland Pittsville Cemetery 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service/Licensee 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien end thed for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Id be detached f ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificete 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Unit (8) Home ဥ 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of de 29c. License number 29d. Date signed (Month, Day, Year) H50497 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) nais (00) E Carroll 31. Date filed (Month Day) egistrar's Signatur 32. State Registrar

			For	State of	Marylan						-	0		7	01702
			1 - State Registrar			Cei	rtificat	te of L	Death			Reg. No	200	<u>/_</u>	34792
10	Physici	ian	Decedent's Name (First, Middle	e, Last)							<ol><li>Date of De Month</li></ol>	eath Da	ay Yea	r	3. Time of Death
	/Medi		Paul		wis			ondon		4= ::	Octobe		4 200		11:30 PM <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution		ber)				Location of	of Death		40	County of De		
	<u> </u>	24	WIcomico Nursi 5. Social Security Number		. Age (In yrs. i	ast hirthday)		alisb	ury If Under	24 Hrs.	8. Date of Bir	th	Wicomi		ace (State or Foreign
В	Funeral Director		222-03-4830	1 <b>∑</b> M 2□F	86	Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, Year	) (	Count	inia
Sale	opcus. Inc		Usual Residence of Decedent				<u> </u>				12 23	172	J VI	- 5	IIII
	how how		10a. State 10b. County		10c. City	, Town or Lo	cation							10	d. Inside City Limits
	e Ma la-f s tified	cto	MD Wicom	ico	Ma	rdela	Sprin	ngs							1 □ Yes 2 No
	or 28	Dire	10e. Street and Number				10f. Zip	p Code				10g. Ci	itizen of What	Count	ry?
	ath w	la	9577 Old Railr					2183					JSA		
	er de Items	Funeral Director	11. Marital Status	12. Was Deced	ces?	s. 13.	Was Dece If Yes, spe	edent of Hi ecify Cuba	spanic Ori ın, Mexicar	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - An Black, Wi		
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	Jy F	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give			1 ☐ Yes	2 <b>X</b> No	Specify:				Specify: W	hit	re ·
21215-0036	hou atura	Completed by	15. Deceden	t's Education		16a. Dece						16b. H	Kind of Busines		
712	in 72 in "in in "in Media	plet	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1-	(or 5+)	(Give life.	kind of wo	ork done d ise retired	luring mos  )	st of worki	ng	I			-
21,	d with giene er tha the	ĕ	6	Conlege (1-	<del>101 3+)</del>	Tru	ck Dr	river				Oi	il Comp	any	7
P	al Hy f other	Be	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	(First, Middle	, Maide	n Surname)		
<u>yla</u>	Ment Ment arkec arkec	힏	George E. Cond	lon					Mami	ie Ke	sselri	ng_			
Maryland	2 sho		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Addres	s (Street a	and Numbe	er or Rura	al Route Numb	er, City	or Town, State	, Zip	Code)
6	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Gloria Smith -	· daughter	Jook D						Snow		ocation - City		
Baltimore,	int of h		1 ☑ Burial 2 ☐ Cremation		tate	lace of Dispo emetery, crei			1				•		
, E	it. Pa ntmer ntant: njury		4 □ Donation 5 □ Other (S		Wic								isbury,		ary1and
Ba	Depar Depar Impor any Ir		21. Signature of Funeral Service	Licensee	1				s of Facili	ъс			al Home		100%
			23a, Part1, Enter the disease, or	complications that ca	used the death								íarylan	_	
1	Obveriates		23a. Part1. Effer the disease, of shock, or heart failure. List Immediate Cause (Final	only ne cause on ea	ch line.	1100	-	10			Disa	40			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (c	or as a consequ	1101E		EN	VAL	-	1/156	4SE		+	
Ja"	Examiner			Bue to (c	as a consequ	zence ory.									
U		Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (c	r as a consequ	uence of):								+-	
	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С											
ő,	e exe ian a urial-1	EX	resulting in death) Last	Due to (o	r as a consequ	uence of):									
8760,	ate b hysic the b	dical		d										+	
9 ×	leath certific attending p	/Me	IF FEMALE;	220 If you guto	ome of preson	2004									
Вох	eath o	Physician/Me	23b. Was decedent pregnant in the past 12 months?		ome propregna th 2 □ Feta int at time of d	Ideath 3□	☐Ectopic p ☐ Other (s		,			- Ï	23d. Date of o Month		ry Day Year
P.O.	ires that the de signed by the a be detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknov		eaur 5L	_ Other (S	pecity)							
σ.	that inded by detail	H.	Part II. Other significant conditi	ons contributing to dea	ath but not resu	ulting in the u	nderlying	cause give	en in Part I	l.	23e. Did	tobacco	use contribute	to th	e cause of death?
ds	uires n sigr lid be	d b	CONCIESTIVE	1+E	ALT	FU	11LUE	25			10	Yes 2	2 □ No 3 □	Proba	ably 10nknown
00	w requir been si should l	lete	ANEMI	A	•	,					24a. Was	an	24b. Were	autor	nsv findings available
Records,	sician; The law certificate has b irector, page 2 s	Completed by	HYPERTENS								auto perf	psy ormed?	death	?	osy findings available apletion of cause of
			25. Was case referred to medica	100					26. Place	e of neath	1 Yes 1 (Check only	one)	o	es	No No
>	Physician: this certificaral director, I	To Be	examiner? 1 ☐ Yes <b>2</b> ☐ No	Hospital: 1 ☐ In	patient 2	ER/Outpatier	nt 3 🗆 D	OA Othe	nr: /	/	, , , , , , , , , , , , , , , , , , , ,	,	6 □Other (S	oecify	·)
J Or	Jing Phys 1. After this funeral di		27. Manner of Death  1 ☑ Natural 5 ☐ Pendir	28a. Date o	f Injury , Day Year)	28b. Time o Injury	f	28c. Injun Work			28d. Describe				
Ö	endir ath. or: Ai he fur	atio	2 ☐ Accident investi	gation			M	1 🗆 '	Yes 2□	No					
Division	r Att	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined 28e. Place of buildin	of injury - At ho g, etc. (Specif	me, farm, str	reet, factor	ry, office		1	28f. Location ( City or To			Rurai	Route Number,
	oltal o irs afi iral D	S													
	Hosp Hou Fune fely fi	edical		ng Physician: To the l Examiner: On the ba	sis of examina										
	To the Hospital or Attending Physimitin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Med	29b. Signature and title of certifie	and manne	er stated.		29	c. License	e number			29d D	ate signed (Mo	nth I	Dav. Year)
	F ≥ F 8		1110.1	1. 4.		112		D-	1-11-1	151-	_	,	2/1/		,,,
	I MIK		30. Name and address of person	who completed cause	of death (Item	23a) (Tuna	Print)	r 0	060	1/3	>	16	11>10	/	7
	LVIX		Maacha Thimm	aravanna M				hore	Dr	Sali	sbury N	1D 2	1804		
	Sta	ate	31. Date filed (Month, Day, Year)	6 2007 32.	gistrar's Signa		1	-							
	Regist	rar	001 1	6 2007	MERKE!	CF AA	There .	<i>P</i>							

			For State Ragistrar	State of Maryland		artment of H tificate of I			giene 20	07	34793
	Physici /Medic		Decedent's Name (First, Middle, Last)     Paul DADE					2. Date of De Month Octobe:		Year	Time of Death 9:45 a. <sup>M</sup>
	Examir Funeral		4a. Facility Name (If not institution, give  Autumn Assisted L 5. Social Security Number  223–18–4386	iving	ast birthday) Yrs.	4b. City, Town, or Hag  If Under 1 Year  Months Days	Location of Deal  erstown  If Under 24 Hrs  Hours Min.	8. Date of Bir	th y, Year)	nington  9. Birthplace Country)	(State or Foreign
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28e-1 show an enty injury or other traumatic event, the Medical Examinant is a confiled at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Virginia Culpeper  10e. Street and Number  10088 Sperryvil	le Pike  12. Was Decedent Ever in U.S. Armed Forces? 1 (X) Yes. 2 □ No. If Yes. Give Year or Dates:  Cation e completed)  College (1-4or 5+)  O  Type, Print)  Son  Removal from State  Cu 1	1 16a. Deced (Give life. See 19b. Mailir 1008 ace of Dispometery, crer peper	eper 10f. Zip Code	specify:  ation furing most of wo yed  18. Mother's Na Blan and Number or R ville Pi  1. 10, ss of Facility	me (First, Middle ache Slau ural Route Numb ke, Culp Date  /23/07 MINNICH	10g. Citizen of W  USA  14. Race Black Specify:  16b. Kind of Bus truckin taxi ca Maiden Sumame aghter er, City or Town, S Deper, Va 20c. Location ( Culpeper FUNERAL	- American lick, White, etc.  black siness/Industring and lib owner  State, Zip Coc.  2270 City or Town,  T, Va.  HOME	Inside City Limits  1  Yes 2 No  ndian,  ck  ry  er
68760,	Pnysician /Medical Examiner	/Medical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	ence of):				rrest,	Ap	proximate erval Between iset and Death
Records, P.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	1∏Live birth 2 ∏ Fetal 4∏Pregnant at time of de 9∏Unknown	death 3 ath 5	Ectopic pregnancy Other (specify)		1 🗆 24a. Was	Monoropacco use contri Yes 2 No	ith Day	ause of death?  y 4 90nknown  findings available etion of cause of
Division of Vital Records,	utending Physician: death. ctor: After this certifica the funeral director. p	Certification; To Be C	25. Was case referred to medical examiner?  1 Yes 2 No I  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	-	28b. Time of Injury me, farm, str	f 28c. Injur Wor M 1 □	er: 4 Nursing	Home 5 Resi		or ( <i>Specify</i> ) ed	
)	To the Hospitel or A within 24 hours after to the Funerel Direct completely filled in by	Medical		32. Registrar's Signat	23a) (Type,	29c. Licens DJ Print) Hagerstov	e number	surred at the time,		(Month, Day	e cause(s)
DH	VIII 17 Dou 1/0	001	UC 194	JUI PROPERTY 1	A. John	Arra days					

aaco hlth dept 10/15/07 dlw tate of Maryland / Department of Health and Mental Hygiene

1- State Registrar

Registrar

1- Registrar

1- Registrar amend item 26 per ph Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Earl G. Douglas 11:59 A M 2007 Oct 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Year) 5. Social Security Jumbe 215-22-5133 215-32-5133 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1**X** M 2□ F 80 Director Oct 09, 1927 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Grasonville MD Queen Anne's 1 ☐ Yes 2√ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21638 348 Prospect Bay Drive West Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Maritai Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or then any Injury or other traumatic event: the Merlinal Eventura 1 TYes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Welding Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Douglas Evelyn Frailer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 348 Prospect Bay Drive West, Grasonville, MD 21638 Joan M. Douglas/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 13, Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Park 2007 21. Sign Jur of Franeral Service License 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition **Physician** ongestive Several years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner atrial hronic year if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? rointestinal bleed 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 1 ☐ Yes 1 🗌 Inpatient မှ 2 XER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) illed in by the funeral 28a. Date of Injury 28b. Time of 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stevensville Suite E Daniel J. Konick MID 115 Jallitt 31. Date filed (Month, Day, Year) 32. Relistrar's Signature State OCT 1 5 2007 Registrar

07-08199 Carli

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

iza L	ynn Dov		I- For St	ate	Sta	ate of	Marylan	id / Depai <i>Ceri</i>	rtment of tificate of	neaim a Death	no Mentarri	F	Reg. No.	20	U /	3419
1	Physicia		Registra 1. Dece	r dent's Nam	e (First, Middle	e,Last)						2. Date of Dea Month October 2	Day Y	ear	3. Time of I 1206 h	
	Examir	ner		rliz		Lyr		Dove		4h City Town	or Location of Death			y of Death	1	
			4a. Faci	ility Name (i	f not institution	n, give str pital	eet and num	ber)	[	Prince Fr			Calver			
	oval			Security N		6. Sex	7	. Age (In yrs. la	ast birthday)	If Under 1 Y		_	linth (MM/DD/YY	I Co	ווחלותיו	
	uneral irector	١		2-94-		1 M	2XF	43	3 Yn		ays Hours Min	March	8, 1964	· Ma	arylan	nd
-		ŀ	Usual F	Residence o	f Decedent			Lia Oii	Town or Loca	tion					10d. Inside	e City Limits
	* any		10a. St		10b. County				usby	(IOI)					1 Yes	s 2 X No
	-f sho	to	MI	reet and Nu	Calve	rt			usby	10f. Zip Cod	e		10g. Citizen of	What Cou	intry?	
J :	e Mar or 28a fied at	Director			Barreda	Blv	Б			206	57		Unite			
	with the s 23a e notil	ral	11. Ma	rital Status		1:	2. Was Dece	edent Ever in U	.S. 13. W	as Decedent of	Hispanic Origin? ( S ban, Mexican, Puert	Specify Yes or I to Rican, etc.)		ace - Ame /hite, etc.	rican Indian,	, Black,
	r death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral	1 🗌	Never Marr	ied 2 XM		Armed For	2 X No	1	-			Spec	ify: W	hite	
	ral", o	by F		Widowed	4 Div	0.1	Yes, Give Year Dates:		160 Doceda	ent's Heural Occ	ination (Give kind of	f work done	16b. Kind o	-	s/Industry	
	"natu Exan	ted	15. D		condary (0-12)		College (1-		during	most of working	life. DO NO1 use re	etired)		wn ho	NM (	
36	thin 72 ne. • than ledical	Completed		12		ļ				Homemak	er 18.Mother's Nan	mo /First Middl	1	_		
5-0036	led wi Hygier other the M	ပ္ပ			e (First, Middle							e Mar		rner		
2121	ld be fi fental narked event,	o Be	_	ordon	Bennet Name/Relation		e, Print )		19b. Mail	ing Address (	Street and Number o	or Rural Route I	Number, City or	Town, Sta	ate, Zip Code	9)
MD 2	shoul and N 27 is n matic	To			A. Beau			band	12	990 Bar	reda Blvd	Date	by, MD	2065	or Town, Sta	ate
e, S	l and Health item r trau		20a. N	Method of D	isposition X Crematic			20b.	cromatory or	osition (Name o other place)						
mor	Pages lent of ant: Il or othe		1 4	Donation	5 Other S	Specify:		M∈	tropol	itan Cr	rematory 1 dress of Facility F	10-26-0	7   Alex	andri	La, VA	
Baltimore,	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items be notified at once injury or other traumatic event, the Medical Examiner must be notified at once		21.	of	uneral Servi	License	e	(	22	. Name and Ad	325 Mt. Ha	kauscii. armonv	Lane, O	wings	s, MD	20736
		_	23a. F	Part I Enter	the disease, o	or complic	ations that c	aused the deat	h. Do not ente	r the mode of d	ying, such as cardia	c or respiratory	arrest, shock,	or heart	Approx	ximate Interval een Onset and
	hysician Medical	1	f	ailure. List	only one caus e (Final diseas	e on each				intoxic				_		Death
	xaminer		or co	ndition resu	ilting in death)	D	ue to (or as a	a consequence	of):							
		Ē	Sequ if any	entially list	immediate		ue to (or as a	a consequence	of):							
		Examiner	cause (Dise	e. Enter Ur	nderlying Caus ry that initiated	· · · -	ue to (or as	a consequence	of):							
	outed nd transit	T X	even	ts resulting	in death) Las	d										
				UNPEND	ED		#23a,27	,28a-f,pe	erME,g87	3, 11/1/0	7 TT		224 [	ate of deli	iverv	
760	cate by	M/Me	IF FE	MALE:	ent pregnant in	the	23c. If yes,	outcome of pr	egnancy 2	Fetal death	3 Ectopic pre	egnancy		nth	Day	Year
.89	leath certificate be exe e attending physician a for use as the burial -	1 2	2 200	past 12 mor	nths?			nant at time of		Other (Specif	y)					
Š	e death the atte	Dhyeic	<u>&gt;</u>		No 9 <b>✓</b> 1		9 Unkr		at reculting in 1	he underlying o	ause given in Part I.	23e.	Did tobacco use	contribut	e to the caus	se of death?
0	that the denet by the detached		Part	II. Other si	gnificant con	ditions	contributing	to death put he	A resulting in t	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1	Yes 2 N			
<u>u</u>	w requires that as been signed b												Was an autopsy	24b. Wei prio	re autopsy fir r to completi	ndings available ion of cause of
į	law re	4 I 4	Completed										performed? Yes 2 No	dea 1 ✔	th? Yes	2 No
å	certificate	ag C		Was case r	eferred to med	ical				2	6.Place of Death (Ch					
Sinisis of Wital Bocords	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys	completely filled in by the runeral director, page	98 0	examiner?	2 No	H	lospital: 1	Inpatient 2			OA Other; N	lursing Home	5 Residence		Other:	
4	After	uneral		Manner of I			(Mor	te of Injury hth, Day,Year)	- 1	1	1 Yes 2 X No					
	or Attend after death. Director:	sy the	catio	Accide	nt Ir	ending rvestigation	28e PI	10/21/200 ace of Injury - A	)/ Fnd I At home, farm,	street, factory,	office building, etc.	28f. Loca	ation (Street and	Number	or Rural Rou	ute Number, City
	DIV	led in	Certification:	Suicide Homici	d	Could not letermined	be   d   (Specif	(v) Calve	rt Memor	ial Hospi	tal	Princ	own, State) ce Freder			
	To the Hospital within 24 hours	tely fil	29a			g Physici	ian: To the b	est of my know	vledge, death	occurred at the	time, date and place opinion, death occu	e, and due to th irred at the time	e cause(s) and e, date and plac	manner a e, and due	s stated. e to the caus	se(s)
	Fo the vithin Fo the	omple	one,				r:On the bas and manne	r stated.			License number		29d. D	ate signed	(Month, Da	ay, Year)
			<b>≥</b> 29b	. Signature	and title of ce	rutier	11.					OME	Octo	ber 22,	2007	
	(6)		200	1 he	odue.	M,	complete	use of death (	Item 23a							7.2
			30.	Theodor	e M. King,	Jr., ME	D. Assis	stant Medic	al Examine		nn Street, Balti	imore, MD 2	21201			
		Sta	ate 31.		Month Day Y		2007 32.	R distrar's Sig	nature	Sperk	7					
					UU	W 0	2001	MICHELLAND OF								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-07976 State of Maryland / Department of Health and Mental Hygiene Darnell Douling 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day October 12, 2007 1745 hrs Medical Examiner DARNELL LAMONT DOULING SR 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Somerset Princess Anne 822 Umes Boulevard 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreian Days Hours Min Director Country) 1XXM 2 212-92-8483 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County YYYes 2 No 28a-f shov SCMERSET PRINCESS ANNE notified at once. MD Directo 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 21853 30733 USA ANTIOCH AVE APT or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages I and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or item or other traumatic event, the Medical Examiner must b 1 X Never Married Married BLACK 2 X No Yes If Yes, Give Year 1 Yes 2 No specify: Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 PROUDUCTION WORKER ALLEN FOODS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JANE DOULING Be FREDDIE LEE WADE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) BROTHER PRINCESS ANNE SHAUN DIOULING 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State WILLIAMS FAMILY CEM. 10-20-07 MARION, MD Other Specify Donation 5 22. Name and Address of Facility Signature of Funeral Service Licensee 917 W. ISABELLA ST. BENNIE SMITH FUNERAL HOME 2180 SALISBURY. MD e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Enter, the diseas **Physician** Between Onset and tist only one cause on each line. /Medical a. Head Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical AMENDED attending physician or use as the burial -UNPENDED Box 68760 23d. Date of delivery IF FFMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Fetal death Live birth 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. <u>۾</u> Yes 2 ✓ No 3 Probably 4 Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? has performed? 1 🗸 Yes Yes 2 certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certifi 25. Was case referred to medical Be examiner? Hospital: Other Residence 6 V Other: Scene FR/Outpatient 3 DOA Nursing Home 5 Inpatient 2 1 V Yes 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Operator of motorcycle in collision FOUND: Yes 2 V No Natural Pending Oct 12, 2007 1739 hrs 2 🗸 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 822 Umes Boulevard, Princess Anne, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 13, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001

State

Registrar

Ana Rubio MD. 31. Date filed (Month, Day, Year)

OCT

Assistant Medical Examiner

2007

32. Segistrar's Signature

Thomas K.

111 Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygie Pe 🛭 🗎 🧻

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3	Ļ	7	9	•
	-			

death with the Maryland

**Physician** /Medical Examiner

ed by the attending physicien and detached for use as the burial-transit certificate be executed P.O. Box 68760 ete has been signed page 2 should be det Records, certificete has this

Division of Vital To the Hospitel or Attending Pt with n 24 hours after death.
To the Funerel Director: After th

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William Daniels 2245 P M 10 2007 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HIOM 100 501186414 TENIASULA REGIONAL MEDICAL Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax Birthplace (State or Foreign Country) **Funeral** Days 1**3**M 2□ F 72 Director 196-28-2210 4/6/1935 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Item 27 is marked other than "netural", or Iteme 23s or 28e-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Millsboro Delaware Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34098 Village Way 19966 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②XNo If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "netural", or Ite 1 Never Married 2 X Marned 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) owner/operator construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William B. Daniels Ellen Keys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pernit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum once. Joan E. Daniels/wife 34098 Village Way, Millsboro, DE 19966 20b. Place of Disposition (Name of cometery, crematory or other place)
St. Peters & Pauls
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/18/07 Springfield, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DOX.C disease or condition resulting in death) Due to (or as a consequence of): Due to (or s a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine resulting in death) Last Due to (\* as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1□ Yes 2□ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ №6 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann Death Certification: 28b. Time of 28d. Describe how injury occurred Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 30. Name and address of person who complet - cause of death (Item 23a) (Type, Print) Carroll St Steg Treuth alisbury MO

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Bellen.

2007

State of Maryland / Department of Health and Mental Hygiene

Physicia /Medica Examine

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminer must be notifiled at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

		1 - State Registrar	Ce.	rtificate of L			g. No. 2007	31,798						
cia		1. Decedent's Name (First, Middle, Last)				Month	Day Year	8:50 A M						
dica	al -	Helen C. Eagleson  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		October	10, 2007 4c. County of Dear							
nine	er													
		Mariner Health of Bethesd  5. Social Security Number 6. Sex 7. Ag	<b>a</b> je (In yrs. last birthday)	Bethes	If Under 24 Hrs.	8. Date of Birth	Montgor 9. Bir	nery thplace (State or Foreign						
al or		577-60-6570 1□M 2⊠F	92 Yrs.	Months Days	Hours Min.	(Month, Day,	, 1915 Ark	ountry)						
	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			-	10d. Inside City Limits						
	ō	DC N/A	Washing	rton				1 ⊠Yes 2 □ No						
	Se l	10e. Street and Number	Washing	10f. Zip Code		10	g. Citizen of What Co	ountry?						
	<u></u>			2001	Q		U.S.							
	era	3818 20th Street, N.E.  11. Marital Status 12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-	14. Race - Ame							
	Completed by Funeral Director	1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 □ X  1 □ Yes 3 □ Yes Give  Year or Dates:	No	If Yes, specify Cuba  1 ☐ Yes 2 X No		Rican, etc.)	Black, White Specify: Am	<sub>te, etc.</sub> rican erican						
	sted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of work	king 1	16b. Kind of Business	/Industry						
- 1	nple	Elementary/Secondary (0-12) College (1-4or	5+)				7 1 1 0							
	ខ្ល	5+	Math	<u>ematician</u>		ne (First, Middle, N	Federal G	overnment						
	Be	17. Father's Name (First, Middle, Last)				•								
	욘	John Franklin Clark	40h Maril	ing Address (Street		Eugenia	City or Town, State,	Zin Codo)						
		19a. Informant's Name/Relationship (Type. Print)												
			ghter 3818				20c. Location - City or							
		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ Removal from State	·	osition (Name of ematory or other plac	1		,							
		4 □ Donation 5 □ Other (Specify)	Rock Cre	ek Cemete	ry Oct.10	6, 2007  T	Vashington neral Serv	, D.C.						
ouce.		21. Signature of Funeral Service Licensee	, , ,											
O	_	Under Show	pson					D.C. 20012 Approximate						
		23a. Part1, Enter the disease, or complications that cause shock, or heart failure. List only one cause on each l	d the death. Do not er ine.	nter the mode of dyin	ig, such as cardiac	or respiratory arre	351,	Interval Between Onset and Death						
n		Immediate Cause (Final disease or conditiona. Dement	ia					10 yrs						
al er		resulting in death)  Due to (or as a consequence of):												
8	L	Sequentially list conditions, b.												
_	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Usease or injury												
	хап	that initiated events c												
	a E		,											
	edical	d												
	Completed by Physician/Me		2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify) _	<i>y</i>		23d. Date of de Month	elivery Day Year						
	h h	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause giv	en in Part I.	23e. Did to	pacco use contribute	to the cause of death?						
	d b					1 □ Y	es 21XINo 3∏ F	Probably 4 Unknown						
ı	lete					24a. Was a	n 24b. Were a	autopsy findings available						
	gmc					autops	med? prior to med? death? 2  No 1 □ Ye	completion of cause of						
		25. Was case referred to medical			26. Place of Dea	1 Yes ath (Check only or								
	o Be	examiner? 1 ☐ Yes 2▼ No Hospital: 1 ☐ Inpat	ient 2 ☐ ER/Outpatio	ent 3 DOA Oth	ier		ence 6 □Other (Sp	pecify)						
	n: To	27. Manner of Death 1 ☑ Natural 1 ☑ Natural 1 ☑ Natural 1 ☑ Natural 1 ☑ Natural	jury 28b. Time ay Year) Injury		<u>_</u>	1	ow injury occurred							
	atio													
	ertifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of ir building, €		28f. Location (S City or Tow	treet and Number or I n, State)	Rural Route Number,								
	28a. Date of injury  (Month, Day Year)  28b. Date of injury  (Month, Day Year)  28c. Injury at Work?  1 Yes 2 No  28c. Injury at Work?  28c. Injury at Work?  28c. Injury at Work?  1 Yes 2 No  28c. Injury at Work?  28c. Injury at Work?  28c. Injury at Work?  1 Yes 2 No  28c. Injury at Work?  28c. Injury at Work?  28c. Injury at Work?  28c. Injury at Work?  1 Yes 2 No  28c. Location (Street and Number or City or Town, State)  28c. Injury at Work?  1 Yes 2 No  28c. Injury at Work?  1 Yes 2 No  28f. Location (Street and Number or City or Town, State)  28f. Location (Street and Number or City or Town, State)  28g. Place of injury - At home, farm, street, factory, office  28f. Location (Street and Number or City or Town, State)  28g. Place of injury - At home, farm, street, factory, office  28f. Location (Street and Number or City or Town, State)  28g. Place of injury - At home, farm, street, factory, office  28f. Location (Street and Number or City or Town, State)  28g. Place of injury - At home, farm, street, factory, office  28f. Location (Street and Number or City or Town, State)													
	Me	29b. Signature and title of certifier		29c. Licens	se number	2	29d. Date signed (Mo	nth, Day, Year)						
			0	mp D53	3528		October 15	5. 2007						
		30. Name and address of person who completed cause of	death (Item 23a) (Type					•						
	18121 Georgia Ave., #103 Olney, MD 20832 Daphna Henkin, M.D.													
Sta	te	31. Date filed (Month, Day, Year) Regis	trar's Signature	and a										
istr	ar	OCT 1 6 2007	as it has	EACL!										

DHMH 17 Rev 1/2001

Registrar

10

		Please 1	Type or Print in E						3		
		1 - For State Registrar	State of Marylan		partment of F ertificate of		Mental Hy	•		217	0.0
	46	Registrar  1. Decedent's Name (First, Middle, Last)	)		ertificate of	Death	2. Date of D	eath	2007	3. Time of D	Death
Physic /Med		Vivian Anne I	Edmanson				Octob	er I	2007	12:05	AM
Exam	iner	4a. Facility Name (If not institution, give Calvert Manor Heal		-	4b. City, Town, o	r Location of Death Sun	1	4c.	County of Death	1	
Funera		5. Social Security Number 6. Se	0 1	last birthda 78 Yrs.	Months Dave	If Under 24 Hrs. Hours Min.		ay, Year)	Cos	nplace (State or untry)	Foreign
Directo		217-26-2416 Usual Residence of Decedent					Feb. 1	3, 19	929 Dela	ware	
larylar show	5	Maryland Cecil		y, Town or Lsing						10d. Inside City 1 ☐ Yes 9	
n the N r 28a-1	irect	10e. Street and Number	10.3	- SING	10f. Zip Code			10g. Cit	izen of What Co		AA.
ath with	ralD	1881 Telegraph Roa			2191				ed Stat		
5-UU30 72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No	.S. 1	<ol><li>Was Decedent of H If Yes, specify Cub</li></ol>	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or N o Rican, etc.)	0-	14. Race - Amer Black, White		
Ours at	5	3 ☐ Widowed 4 ☐ Divorced	1		1 ☐ Yes 2 ☐ No	Specify:			Specify: Wh	ite	
n 72 h "natu edical	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	1 (G	cedent's Usual Occup ive kind of work done b. DO NOT use retire	during most of wor	king	16b. K	ind of Business/I	ndustry	
d withing giene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	f	sistant Tr	,		Ва	nking		
DESIGNATION CE, INICITY STATE A SECURGE PROTOCO TO PROTOCO THE MATCH TO POPULATE PROTOCO THE MATCH TO POPULATE PROTOCO THE MATCH TO POPULATE PROTOCO THE MATCH PROTOCO THE PROTOCO THE MATCH PROTOCO THE MATCH PROTOCO THE PRO	To Be C	17. Father's Name (First, Middle, Last)  James Albert Edr	nanson			18. Mother's Nar Mary	ne (First, Middl Virgini	,	- /		
d 2 shoul th and M 7 is marl traumati	F	19a. Informant's Name/Relationship (7)	vpe. Print)	19b. Ma	ailing Address (Street	and Number or Ru	ırai Route Num	ber, City o	or Town, State, 2	ip Code)	
e, IV 1 and 2 Health em 27 ther tra		Kevin J. Kirk / Ne			Mariners C	ourt, E1	oton, M		and 219		
nor ages ent of 8 nt: if its		15 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify,	Removal from State	cemetery, c	rematory or other pla	, 000	ober		•		1
Dallinor permit. Pages Department of Important: If it any injury or o	Š	21. Signature of Juneral Service Licer	1981	. CII Ea	ast Method 22. Name and Addre	ess of Facility C	rouch F	unera	in East, 11 Home	Marylai	na
_ %&£ % &	54	Mult Che	Tel C		127 South	Main Str	eet, No	rth E			
Physiciar		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.		1 -,	_	or respiratory	arrest,		Approximate Interval Between Onset and De	eath
/Medica	l	disease or condition resulting in death)	aDue to (or as a conseq	mence of.						unknow	n
Examine		Sequentially list conditions,	b. Due to (or as a conseq	COP	D + CM	movic a	4F			unknow	M
executed n and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Idiopath	ic / :	D + Ch Ischaeni	c Hear	e cline	ani		unkno	m
be executed ician and burial-transit		resulting in death) Last	Due to (or as a conseq								•
oo/ ificate t g physical as the b	edica	•	d								
ath certi	M/ne	23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta		3 □Ectopic pregnanc	v			23d. Date of deli	•	
law requires that the death certificate as been signed by the attending physics should be detached for use as the it.	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4☐Pregnant at time of c 9☐Unknown		5 Other (specify)	,			Month	Day Ye	ear
5, <b>7</b> . In sthatt In ed by e detad	by Ph	Part II. Other significant conditions co	entributing to death but not res	ulting in the	e underlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of de	ath?
law requires t as been signe							1 [	Yes 2	□ No 312 Pr	obably 4 □Ur	nknown
The law ate has b	Completed							s an opsy formed?	24b. Were au prior to death?	topsy findings av completion of cau	vailable use of
VICAL Iclan: T Sertificate ector, pa	Be Co	25. Was case referred to medical examiner?		: - : -		26. Place of Dea	1□ Yes ath (Check only		1 ☐ Yes	2 <b>0</b> /No	
Or V Physic r this ce	2	1 ☐ Yes 2 M No			tient 3 DOA				6 □Other (Spec	cify)	
VISION OF VILA  Attending Physician: or death. rector: After this certifical by the funeral director.	tion:	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injur	y Wor	ryat rk? ∣Yes 2 □ No	28d. Describe	e how inju	ry occurred		
or Atter	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Specia	l ome, farm, fy)	street, factory, office		28f. Location City or To	(Street ar own, State	nd Number or Ru e)	iral Route Numb	er,
To the Hospital or Attending Physician: The law requires that the death certificate be executivitin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-france.		29a. Certifier Certifying Phy	rsician: To the best of my kno iner: On the basis of examina	owledge, de	eath occurred at the ti	me, date and place	e, and due to th	e cause(s	) and manner as	stated.	
o the hithin 24 o the Formplet	Medical	one)  29b. Signature and title of certifier	and manner stated.		200 Linear				te signed (Monti		
⊢ s ⊢ ŏ		DQ 17-	NITIN 1	JERIME		00663	27				
6		30. Name and address of person who c	ompleted cause of death (Iter	n 23a) (Typ	51.0				<i>J</i>		_
	tate trar	31. Date filed (Month, Day, Year) OCT 15	2007 SL Li	ature	food		<u> </u>				

	For State Registrar	State of t	waryland		artment of H rtificate of L		d Mental Hy	/giene Reg. NG.	007	34800
	1. Decedent's Name (First, Middle,	Last)			4		2. Date of D Month		Year	3. Time of Death
ysician Medical	Zyama	Flider					October		2007	11:05 p
miner	4a. Fecility Name (If not institution,	give street and numb	er)		4b. City, Town, or	Location of E	eath	4c. C	ounty of Death	1
	Hebrew Home of Gre			1 5 1 4 1 1 1	If Under 1 Year	Rockvil If Under 24			Montgom	
	5. Social Security Number 218-37-1664	5. Sex 7. 1⊠M 2□F	Age (In yrs. las	Yrs.	Months Days		Hrs. 8. Dale of B (Month, D October		Cou	place (State or Foreig Intry) Sia
	Usuel Residence of Decedent		71				october	J, 17.	LO Rus	SIA
	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limit
Director	Maryland Montgo	omery			Rock	cville				1 ⊠ Yes 2 □ N
Dire	10e. Street and Number				10f. Zip Code			10g. Cilize	en of What Cou	intry?
	95 Dawson Avenu	<del></del>				20850			U.S.	
Funeral	11. Marital Status	12. Was Decede Armed Force	es?	13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin n <b>, Me</b> xican, P	? (Specify Yes or Nuerto Rican, etc.)	0- 14	<ol> <li>Race - Ameri Black, White</li> </ol>	
by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 If Yes, Give Year or Date	_		1 ☐ Yes 2 🖺 No	Specify:		5	Specify:	aucasian
ed	15. Decedent	Education		16a. Dece	dent's Usual Occupa	ition		16b. Kind	d of Business/Ir	
plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4	05.51	(Give life.	kind of work done o DO NOT use retired,	luring most of )	working			
Completed by	12	College (1-4	01 3+)		Laborer				Retail G	rocery
Bec	17. Father's Name (First, Middle, L	ast)				18. Mother's	Name (First, Middle	e, Maiden S	umame)	
10	Issac Flide	er					Rachel	Unknowi	1	
	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Street a	and Number o	r Rural Route Numi	ber, City or	Town, State, Zi	ip Code)
	Yakov Shapiro - So	n-In-Law			+ Emerald Dr	cive, Ge		3		
	20a. Method of Disposition 1   Burial 2 □ Cremation	3 □Removal from Sta	con	ce of Dispo netery, crer	sition (Name of natory or other place	9)	Date	20c. Loc	ation - City or T	own, State
	`4 ☐ Donation 5 ☐ Other (Sp	ecity)		an Memo	orial Garder	1	0/16/2007	01ne	ey, Maryl	and
	21. Signature of Funeral Service	mensee) ///			. Name and Addres ines-Rinaldi		1 Home, Inc.			
Ц.,	23a. Part1. Enter le disease, or o shock, or he in failure. List o	Wille	ane it	1	L800 New Han	pshire	Avenue, Sil	ver Spr	ing, Mar	yland 20904 Approximate
al Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	as a consequer as a consequer as a consequer	nce of):	10N IA					Onset and Death
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnan 9□Unknow	n 2 ∏ Fetal de tat time of deam	eath 3 c	Ectopic pregnancy Other (specify)				ld. Date of delin	Day Year
ted by	Part II. Other significant condition	SE DE	MEN7	/A	nderlying cause give	in in Part I.		Yes 2		the cause of death? bably 4 Onknow
Comple							24a. Wa auto peri 1 □ Yes	s an opsy ormed? 2 No	24b. Were aut prior to codeath?	opsy findings availab ompletion of cause of 2 \sumbed No
Be	25. Was case referred to medical examiner?	Hospital:			Othe	_	Death (Check only	ona)		
- To	1 Yes 2 No 27. Manney of Death	1 - 1ub		Outpatier  Bb. Time of		4 Latiursii	ng Home 5 ☐ Res 28d. Describe			ity)
盲	1 Attural 5 Pending		Day Year)	Injury	Work	:? ∕es 2⊡No	200. 0000100	now anjury	occarrod	
Certification:	3 Suicide 6 Could not determine	ot be 28e. Place of	Injury - At home etc. (Specify)	e, farm, str	eet, factory, office		28f. Location City or To	(Street and own, State)	Number or Rui	ral Route Number,
edical (	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the be xaminer: On the basi and manner	s of examination	edge, death n and/or in	n occurred at the tim vestigation, in my op	e, date and pointion, death	lace, and due to the occurred at the time	cause(s) a , date and p	nd manner as lace, and due	stated. to the cause(s)
Me	29b. Signature and title of certifier	Complex	M	D	29c. License D 2 Print) 121 Wow		2		signed (Month	
	- V III	11 001								

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34801 Reg. No.2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DONALD ALDINE FOX October 0324 AM 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Sex XXM 2□F Months Days Hours 215-36-7284 73 Maryland June 4,1934 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes XXNo Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9634 Cafoxa Drive 21795 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Utility Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clyde Ambrose Fox lve Virginia Bowers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21795 <u>LaRue A. Fox - Wife</u> 9634 Cafoxa Drive Williamsport, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cedar Lawn Mem. Park Oct.17,2007 Hagerstown, Maryland gnatur OSDOPINE AFTER EFEITY Home, P.A. 425 S. Conococheague St. Williamsport, MD 23a. Lent 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DISEASE ATHEROSCUEROTIC HEART Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of perform death? 1 ☐ Yes 1∐ Yes 2 □ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 No 1 Inpatient 2 KER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 5 ☐ Pending investigation Natural

**Physician** /Medical Examiner

burial-tran

the as attending properties for use as

signed t

director, page 2 s

this funeral

After t

after death. death.

Hospitai or To the Hospital of within 24 hours at To the Funeral I

filled in by the

physician

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Director

Funeral

ģ

Completed

Be 2

**Funeral** 

Director

show 28a-f sh notified

o e ms 23a (must b

'natural", or items dical Examiner mo

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'nature any injury or other traumatic event, the Medical once.

with the Maryland

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

Examiner

Physician/Medical þ Be Completed

Certification: To

Medical

IF FEMALE:

2 Accident

3 Suicide

4 Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

D0061411

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of ce 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAHES H KRISHNAMODRTHY [1]] MAHESH

IIIIO Medical Campus Rd Ste 150

Hagerstown

200

5H-5 State

31. Date filed (Month, Day, Year) 7 OCT

6 Could not be determined



M.D

Registrar

State of Maryland / Department of Health and Mental Hygien 90734802 1 - For Stete Registrar Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** OCTOBER 6,2007 5:00 A DONALD GARY FOOR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner QUEEN ANNE'S 602 KIMBERLY WAY STEVENSVILLE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F Yrs DEC. 27,1952 MARYLAND Director 54 214-52-9647 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location 10b. County in than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No STEVENSVILLE QUEEN ANNE'S MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21666 602 KIMBERLY WAY death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hyglene. ant: if item 27 is marked other than "natural, or Iten ury or other traumatic event, the Medical Earn/inst ury or other traumatic event, the Medical Earn/inst 1 Never Married 2X Married 21215-0036 WHITE 1 ☐ Yes 2X No Specify: by If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BRIDGE CONSTRUCTION PILE DRIVER 12 -0-Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be DONALD M. FOOR DORIS RITCHEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 602 KIMBERLY WAY, STEVENSVILLE, MD 21666 BRENDA FOOR/ WIFE Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. injury or CHESAPEAKE CREMATION 10-8-2007 STEVENSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Fune al Service kicensee 22. Name and Address of Fac FELLOWS, HELFENBÉIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ALCOHOLIC CIRRHOSIS OF LIVER 5 YRS. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence ol): Box 68760 Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year ō Month 5 Other (specify) pe Ö the 9 Unknown 9 Unknown signed by ۵ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown RENAL INSUFFICIENCY Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2**X** No Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 2 1 ☐ Yes 2 ▼ No 2 ER/Outpatient 3 DOA Maridence 6 ☐ Other (Specify) this 27. Manner ol Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After 1 XNatural 5 Pending Injury after death.

Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a. Certifier (Check only one the 29c. License number 29b. Signature and title of certifie D32353 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 135 SALLITT DRIVE, SUITE E, STEVENSVILLE, MD 21666 DANIEL J. KONICK, M.D.,

State Registrar 31. Date filed (Month, D) (Petr)

20072. Register's Signature

			1 - For State Registrar	State	of Marylar		ertment o			fental H	lygie Reg.	Z 1111 /	34803
			1. Decedent's Name (First, Middle	, Last)		-				2. Date of Month		Day Year	3. Time of Death
	Physici /Medio		JAMES OAKWARD I	FERRELL						OCT.	5	2007	05:12A M
	Examir		4a. Facility Name (If not institution,	•			4b. City, Tow					4c. County of Dea	th
			CHESTER RIVER			land himbalan	CHEST	ERTOW	N der 24 Hrs.	0 8242 24	Diah	KENT	the Leave (Charles on Francisco
da c	Funeral Director		5. Social Security Number 214-42-9124	6. Sex 14 M 2 ☐ F	7. Age (In yrs. 63	**	Months Da			8. Date of (Month, 5/2	Day, Ye	ear) 9. Bir	thplace (State or Foreign ountry) DE
			Usual Residence of Decedent		03					3/2	2/ 1	T	
	nyland how		10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	8a-1	cto	MD Que	en Anne's	s M	filling	ton						1 Yes 2 No
	or 24	Dire	10e. Street and Number				10f. Zip Coo				10g.	Citizen of What Co	ountry?
	s 23	Funeral Director	403 Spring Rd.	40 1W D-		16 101		651	0-1-1-0 (0-		N-	USA 14. Race - Ame	don Indian
	Item Iner	-un-	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie	Armed F	cedent Ever in U orces? 2 □ No	J.S. 13. V	Was Decedent f Yes, specify (	of Hispanic Cuban, Mexic	can, Puerto	Rican, etc.)	NO-	Black, Whit	e, etc.
99	urs af	þ	3 Widowed 4 Divorced	If Yes, G Year or	ive	1	I□Yes 2\	No Speci	ity:			Specify:	Black
Š N	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23e or 28e-1 ehow ent, the Medical Examiner must be natified at	Completed	15. Decedent' (Specify only highes	s Education	1)	16a. Deced	lent's Usual Oc	cupation	ost of work	ina	161	. Kind of Business	/Industry
2	ithin 19	nple	Elementary/Secondary (0-12)	1	/ (1-4or 5+)		kind of work do DO NOT use re		iost or work	y			-
2	led w lygier her th		12 17. Father's Name (First, Middle, L	antl		L:	ine Wor		shede Nam	- (fire at 8 fints	ette. Adai	Automobi	Ţe
Maryland 21215-0036	ould be filed within Mental Hygiene. Perked other than	Be	James William Fe							Fletc		den Sumame)	
Ž	should ind Men i marke umatic	ို	19a. Informant's Name/Relationsh			19b. Mailin	o Address (Str					ity or Town, State,	Zia Code)
			Doreen Ferrell/V				Spring			ngton,			.,
ē,	s 1 ar		20a. Method of Disposition			Place of Dispo	sition (Name o	f		Date	_	. Location - City or	Town, State
Ê	Pages nent of int: # It		1 XBurial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp			lock V			10/10	0/07	Hι	ırlock, M	D
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is eny injury or other tra ance.		21. Signature of Funeral Service L	icensee	. hei							fenbein D 21620	& Newnam
25	南		23a. Part1. Enter the disease, or	complications that	caused the dea	th. Do not ent	er the mode of	dying, such	as cardiac	or respirator	/ arrest,		Approximate
	Physician		shock, or heart failure. List of Immediate Cause (Final	only one caruse on	each line.	1-0 > 7	A	+	IFA	0-1			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to	(or as a conse	quence of):	-47	1	VIA	Kunc 1.	1		
а	Examiner		Conventingly list conditions	h	HYP	ERTT	ENSI	Dis					
	D ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	quence of):			A				
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conse	ECI	[ PIC	XEPY.	DYT	-			
8760,	ficate be executed physician and is the burial-transit			Due to	(or aspa conser	quence or;							
287	physics the I	dical		d					·				
Box	The law requires that the death certificate be executed at the as been signed by the attending physician and bage 2 should be detached for use as the burial-transit	n/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn							23d. Date of de	livery
	death e atte	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Preg	birth 2 ☐ Fet mant at time of		Ectopic pregna Other <i>(specit</i> y				_	Month	Day Year
o.	at the de by the a tached	hys	9 Unknown	9□ Unk									
_	uires tha signed I d be det		Part II. Other significant condition	ns contributing to	death but not re	sulting in the ur	nderlying cause	given in Pa	ırt I.				the cause of death?
ord	w requir been s	ted								11	Yes 	2€No 3□P	robably 4 Unknown
Records,	slaw hasb e2st	Completed								24a. W	topsy	prior to	utopsy findings available completion of cause of
										1 □ Ye	rformed s 2		2 □ No
Vital	ysician: The law Is certificate has E director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				Othor		h (Check on	- HE-12	25.5	-
o	Phys r this aral dii	1: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 L	Inpatient 2 A of Injury of, Day Year)	28b. Time of	28c. I	njury at				e 6 □Other (Spe injury occurred	cify)
O	nding I th. : After s funer	tior	1 Matural 5 ☐ Pending 2 ☐ Accident investig		nth, Day Year)	Injury		Work? 1 □ Yes 2					
Division of	I or Attendi after death. Director: A	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	280. Plat	e of Injury - At h	nome, farm, str	eet, factory, off	ice		28f. Location	n (Stree	t and Number or R	ural Route Number,
	tal or A	Cert	TO MOREO	Dulk	Jing, etc. (Speci	(1 <b>y</b> )				Ony or	, Own, C	nate)	
	Hospi 4 hours uner		(Check only 2 Medical E	xaminer: On the	basis of examin	owledge, death	occurred at the	e time, date	and place, death occur	and due to t	he caus	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director,	Medical	one) 29b. Signature and title of certifier	and ma	nner stated.			ense numbe				Date signed (Mon	
	T wil		255. Signature and title of certifier	10	-	17	230. 210	>/-	75 11	2	2.30.	12/7/	5 5 J
	10		30. Name and address of person v	who completely	ise of door its	7 .1	Bright)	75	04		(	0/5/2	700
_	+		30. Name and address or person of	10/	6 29 (Ite	Beilro	ad As	e Ce	Arei	ille.	Mr	21617	-
	Sta	te	31. Date filed (Month, Day, Year)		Registra s Sign					-1			
	Registr	ar	ስርፕ	0 9 2007	- Anna	are A	A. A.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Fleath and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Theresa Gray /Medical 2007 10:00 p October 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges Community Hospital Cheverly
If Under 1 Year | 11 Under 24 Hrs. Prince Georges 5. Social Security Numb 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 1 □ F Director 216-06-<del>2105</del> 36 July 24. 1971 Washington, D.C. Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at Director Maryland Prince Georges 1 ✓ Yes 2 No Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Sutton Court Funeral 20774 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after a Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 Nidowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be end 2 should be ealth and Mental William Allen Delena Wiggins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other traconce. Delena Robinson /Mother 7 Sutton Court Upper Marlboro, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Cemetery Oct.20,2007 Tarboro, N.C. 21. Signature of Funeral Service License 22. Name and Address of Facility
Alexander S. Pope. P.A.
5538 Mariboro Pike/Forestville, Md. 20747 23a. Pal 1. Enjer the disease or complication is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enterococcal **Physician** /Medical Examiner Zuterocoecal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Gaugnevers death certificate be executed physician and the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Po in the past 12 months? Month Day Year 4⊡Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t Yes 2K No 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♣ No 24a Was an autopsy performed? this certificate has or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 5

Registrar

DHMH 17 Rev 1/2001

State

B

Greenway Center Drive Greenbelt und 20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EP2114 7525

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death oct.15,2007 **Physician** Estela Russi Garst 2:05am M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Anne Arundel Crofton Convalescent Center | Hunder 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month Days | Hours | Min. | Dec. | 8, 1 92 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 XF Santiago, Chile 392-62-6676 85 Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director MD Anne Arundel Crofton 1 **X** es 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 2131 Davidsonville Road 21114 USA death v Funeral 7 is marked other than "natural", or items traumatic event, the Medical Examiner mo 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 Married Specify: White 1

Yes 2□No Specify: Chilean \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F Alegario Russi Zunilda M. Russi ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 11805 Bishop's Content Road Mitchellville,MD 20721 Patricia Trunnell/Daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 Removal from State ₹ Oct 16, Department o Important: If any injury or once. ò Metropolita Crematory Alexandria, Va. 4 □ Donation 5 ☐ Other (Specify) 2007 21. Signatur of Fyneral Service Licenses 22. Name and Address of Facility <sup>22. Name and Address of Facility</sup> Beall Funeral Home 6512 NW Crain Hwy.Bowie Md 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ovlmonary disease nmediate Cause (Final Physician -Aronic oyears disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: Certification: To 4XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 □ FR/Outpatient 3 □ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident (Month, Day Year) 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 24 hours after death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Division or Vital Records,

P.O. Box 68760,

Baltimore, Maryland 21215-0036

within 24 hor To the Fune completely f

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Brint) Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ense thuy, Crufton, MP 21114

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day GIBBONS Month **Physician** 10:50AM 2007 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pawie Larkin Chase Nursing Home ince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at Carrollton Yes 2 □ No Completed by Funeral Director George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 8407 12. Was Decedent Ever in U.S. Amyed Forces? 1 M Yes 2 □ No I/Y s, Give Year or Dates: 1913 - 52 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Man ress Governmen ages 1 and 2 should be filed voil of Health and Mental Hygie t: If item 27 is marked other? y or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gibbons 8407 Halissa St. New Carrollton Hd 20184 Betty Ceasar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cheltenham Hd heltenham 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope V-unerou Home 5538 Mariboro Pine Forestville md 23a. Part1: En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or The law requires thet the death certificate be executed as the burial-transit IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day ō in the past 12 months? Month Year 5 Other (specify) Division of Vital Records, P.O. ☐Yes 2☐No 9 Unknown 9 Unknown cate has been signed by page 2 should be detac Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2010 1 Yes 2 No 1 Yes : After this certifica stuneral director, p or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ို 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 Tes 2 No investigation 2 Accident filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certifieg 29c. License number 29d. Date signed (Month, Day, Year) on who ampleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

Day, Year)

OCT 1 7 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** October 0 2007 Alan Royer Gnau /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 05/24/1945 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign
Country) Funeral Maryland 62 215-42-6372 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a State 10h. County r 28a-f show notified at 1 ☐ Yes 2 X No Director Anne Arundel Maryland Mayo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be r USA 1128 Carrs Wharf Road 21106 Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 years Construction 0wner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry George Gnau Evelvn Rover ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1128 Carrs Wharf Rd., Mayo, MD 21106 Constance E. Schrom/Girlfriend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Kalas Crematory 10/17/07 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final rdiovascu Physician disease or condition resulting in death) /Medical (or as a consequence of): Examiner DEFTE ASIOT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due for as a consequence of). Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 □ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[X:No Hospital: 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28h Time of 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 💢 Natural 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State Registrar

Medical

29a. Certifier

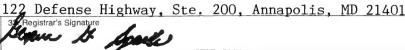
29b. Signature and title of certifier

maria

Maria Romero, M.D.

Komero

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 8 per fib 8874 12 4-07 yt.

State 8 Maryland Department of Health and Mental Hygiens 0 0 7

				State of Mary	/land	ኞ <b>ው</b> epa <i>Cer</i>	trimet tifica:	nt of H te of L	ealth a Death	and Me	ental Hy	giene	2007	34	809
			Registrar  1. Decedent's Name (First, Middle, Las	et)						- 2	2. Date of De	eath			e of Death
	Physici		Vina M			Gard	ner				Month Oct 1	3 Da	y Year 2007	5:45	5 P <sup>M</sup>
	/Medic	- 4	4a. Facility Name (If not institution, give			Julu		, Town, or	Location of				c. County of De		
Di -			Brinton Woods	Nursing &	Re	hab			vill				Carı		
F	uneral		5. Social Security Number 6. S			st birthday)	If Unde Months	r 1 Year Days	If Under Hours		B. Date of B (Month, D			irthplace (Sta Country)	te or Foreign
D	irector		543-30-8753	77	'	Yrs.					Aug 3	0 1	930	Orego	on
pue	<b>*</b>		Usual Residence of Decedent  10a. State 10b. County	10	oc. City,	Town or Lo	cation							10d. Inside	e City Limits
Maryl	f sho	ō	MD Carro	211	Syke	svill	.e							1 🗆 1	′es 2∏No
death with the Maryland	r 28a- notif	Director	10e. Street and Number		_		10f. Zi	p Code				10g. Ci	itizen of What	Country?	
h with	3a ol st be		1442 Buckhorn Ro	ad				21	784			118	3		
deat	er mu	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S.	13.1	Was Dece	edent of H	ispanic Ori	igin? (Spec n, Puerto R	ify Yes or Nican, etc.)		14. Race - An Black, Wi		,
after	or its		1 Never Married 2X Married	1 ☐ Yes 2 ☑ No If Yes, Give			1 ☐ Yes	2/2 <b>X</b> No	Specify:				Specify:	White	
within 72 hours af	ural", al Exa	d by	3 Widowed 4 Divorced	Year or Dates:	_	16a. Dece	dant'e He	ual Occum	ation			16b. h	Kind of Busines		
2 2	"nat edica	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	kind of w	ork done o use retired	durina mos	t of workin	g			,	
with A	than the M	m o	Elementary/Secondary (0-12)	College (1-4or 5+)		Accou	ıntan	t					Food	CHAIN	٥.
be filed	or Tyglenc.  d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last,						18. Moth	er's Name	(First, Middle	e, Maide	n Surname)		
aryland should be file		TO B	Sam J. Lindl	ev					Lau		Belle		Kirb		
2 sho	r hearn and Mental hyglene. item 27 is marked other than other traumatic event, the Me		19a. Informant's Name/Relationship (	Type. Print)									or Town, State	e, Zip Code)	
and and	item 27		Arthur Gardner	husban		6901 ce of Dispo			kett		Woodh		MD 2	1797	
Pages 1	or off		20a. Method of Disposition  1★★Burial 2 □ Cremation 3 □		car	metery cire	matory or	other plan	ce)		19, 20			, Idaho	
Saltimor bermit. Pages	tant:		4 □ Donation 5 □ Other (Specif	"	Tuai				ss of Facili		17, 2	φοί	DOISE	, idanc	
	Department of Important: if it any injury or once.		21. Sign tun of Funeral Service Licer	INIAM							al Ho	me &	Crematield, N	gry, Pa	<b>}</b> /.
			23a. Part1. Enter the disease, or com	plications that caused the	e death.	Do not en	ter the mo	ode of dyir	g, such as	cardiac or	respiratory	willi arrest,	rera, r	Approx	
Db.	A p		shock or heart failure. List only one cause on each line.												and Death
A	ysician /ledical		disease or condition resulting in death)	aDue to (or as a c			77							100	<i></i>
Ex	aminer			h											
77		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Unioritying Cause (Disease or injury	Due to (or as a c	onseque	ence of):									
ecute	trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	0000000	nnoo of):									
8/6U, ate be ex	ohysician and the burial-transit	<u>E</u>	Tobaking in dodati, add	Due to (or as a c	onseque	nice oi).									
death certificate be executed	physi the k	dical		<b>_</b> d											
OX C	attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf									23d. Date of	delivery	
eat a	atter for u	ciar	in the past 12 months?	1 ☐Live birth 2 € 4 ☐ Pregnant at tin			⊒Ectopic ⊒ Other (	pregnancy specify)	/				Month	Day	Year
Ç ş	y the achec	nysi	9 Unknown	9□Unknown											
Hecords, P.O. The law requires that the	signed by the a be detached f	by P	Part II. Other significant conditions			ting in the u	inderlying	cause giv	en in Part	l.			use contribute		
rd.	been sig should b		Cevellionose		SP		-	-			1	] Yes	2 4 No 3	Probably 4	1 Unknown
VITAL RECOLDS, sician: The law requires t	as be 2 sho	Completed	Multpale S	Elenosis							24a. Wa	opsy	prior	autopsy find to completion	ings available of cause of
	ate ha	E O	,								per 1□ Yes	formed? 2 ⊒⊀	death 1□1		
/Ita	ertific ctor,	Be	25. Was case referred to medical examiner?	111						e of Death	Check onl	one			
Jr.	this o	မ	1 Yes 2 No	Hospital: 1 Inpatient		R/Outpatie			4 G N				6 ☐Other (5	Specify)	
Ing F	After funera	ion:	27. Manner Death  1 Latural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Y		Injury	M	28c. Inju Woi	rk? Yes 2⊑		.ou. Describ	e now m	jury occurred		
DIVISION OF I or Attending Phy	after death. <b>Director:</b> After this certificate has in by the funeral director, page 2.	icat	3 Suicide 6 Could not b	e 280 Place of injuny	· - At hon	ne, farm, st					8f. Location	(Street	and Number o	r Rural Route	Number,
בַּ בַּ	after Dire	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	)				V	City or T	own, Sta	ate)		
spita	within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director, I	ac	29a. Certifier 1 CertifyIng P	hysician: To the best of eminer: On the basis of e	my know	/ledge, dea	th occurr	ed at the ti	me, date a	and place, a	and due to the	ne cause	(s) and manne	r as stated.	usa(s)
he Ho	n 24 l he Fu plete	ledical	(Check only 2 Medical Exa	and manner state	xamınatı d.	on and/or i				atri occum	ed at the tim	1			
Tot	To t	ž	29b. Signature and title of certifier					7 -	se number			29d. [	Date signed (M	lonth, Day, Ye	ar)
	1		Faller 7 ww	200				y a	1806			19	12/2007	<i></i>	
.1	K		30. Name and address of person who	completed cause of dea		. / .=	, Print)	an.	/ iRch	ry FO	1 5	Den	SBURG	40	1781
	1 /		31. Date filed (Month, Day, Year)	Donietrar'		ure (0)	-/ /	u ·	-1//1	(10	E	NCR	SISURU	-W C	115/
	St	ate	GCT 1 5 20	77 1900000	K	Aus	1								

State of Maryland / Department of Health and Mental Hygien 00

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month  $\mathbf{A}^{\mathsf{M}}$ Gilmer **Physician** 2007 5:00 Marjorie **OCTOBER** 11, /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner QUEEN ANNE'S GRASONVILLE 1727 PERRY'S CORNER ROAD If Under 1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ☐ M 2 💢 F Yrs. DECEMBER 10,1928 PENNSYLVANIA 186-22-6807 78 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County I Hygiene. other than "natural", or items 23a or 28e-1 arro-vent, the Medical Exercitivat must be notified at 1 ☐ Yes 2X No GRASONVILLE Director OUEEN ANNE'S 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21638 USA 1727 PERRY'S CORNER ROAD Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 21215-0036 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) ACME SUPERMARKET -0-BAKERY MANAGER 12 ith and Mental Hygir 27 is marked other r traumatic event, is 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Peges 1 and 2 should be SARA MANN JOHN HOWARD BLACK 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1727 PERRY'S CORNER ROAD, GRASONVILLE, MD 21638 H.B. GILMER/ HUSBAND f Health item 27 i other Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition i i i 1 

■ Burial 2 □ Cremation 3 □ Removal from State CHESTERFIELD CEMETERY 10-15-2007 CENTREVILLE, MD permit. Peg Department Important: I any injury o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBÉIN & NEWNAM FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately Councillated Councillations (Figure 2016). Approximate Interval Between Onset and Death Meta static Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 2 Fetal death Year 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death Month Day jo 5 Other (specify) 1 ☐ Yes 2 🕱 No P.O. detached 9 C Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an autopsy certificate has > No 1 Yes To the Hospitel or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ٩ 1 🗀 Yes this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Medical Certification: After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after deat Funerel Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signatur, and title of certifier HO057921 0.0, impleted cause of death (Item 23a) (Type. Print) Centre 116 Road, Centre 11k, Maryland alerie Goldman Dio. 32. Registrar's Signature 31. Date liled (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34811 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Haley 15:00 M 200 dward October /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Date of Birth (Month, Day, 1/14/ Birthplace (State or Foreign Country) Voar Days 1**X**M 2□F 83 Yrs. 031-10-8813 1924 Massachusetts Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No **Funeral Director** Harford Jarrettsville MD. 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 2902 Calliston Court 21084 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WW I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo II Specify: Be Completed by 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Stephen Haley Mary Agnes Desmond ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mark E. Haley 2902 Calliston Ct. (Son) Jarrettsville, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Highview Mem. Gardens 10/29/07 Fallston, Maryland 21. Signature of Funeral Prvice Lensee 22. Name and Address of Facility Jarrettsville, Maryland 28 Son Funeral Home. Kurtz 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia dave Obstructive Pulmonary Disease 204
squence of: Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Be Completed by Medical Certification: To

**Examiner** The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

sician and burial-trans ed by the a detached f certificate has been signed l rector, page 2 should be det

**Funeral** 

Director

r 28a-f show notified at

filed within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any InJury or other traumatte event, the Medical Examiner must be r

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Inrector: After this certifica completely filled in by the funeral director, p

that initiated events resulting in death) Last	c. Orong/y/1718.  Due to (or as a consequence of):	ry Disease	2	33 7 23.73
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	ontributing to death but not resulting in the underlying	g cause given in Part I.		use contribute to the cause of death?
			1 ☐ Yes 2	□ No 3 Probably 4 Unknown
			24a. Was an autopsy performed? 1  Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 ∐Yes 2 ▼ No
25. Was case referred to medical		26. Place of Death	(Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other: 4 Nursing Hor	ne 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1	28c. Injury at Work? 1 Yes 2 No	28d. Describe how inju	ry occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, fact building, etc. (Specify)	tory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
	ysician: To the best of my knowledge, death occurr niner: On the basis of examination and/or investigat and manner stated.			
29b. Signature and title of certifier	1 2 1 2 1	29c. License number	29d. Da	ate signed (Month, Day, Year)
Stanial The	Strong Medical Dodor	RES-000	Occ	Johan 24.2007

State Registrar

Vaniel

31. Date filed (Month, Day, Year)

600 North Wolfe Street, Baltamore, MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

he Johns

32. Registrar's Signature

			1 - For State Registrar	· ·	irtment of Health and Menti tificate of Death	Reg. N2 0 0 7	34812								
2	Physici	an	Decedent's Name (First, Middle, Last)     Mamie	B. Hill		ate of Death onth ober 9, 2007	3. Time of Death								
	/Medic Examir	al	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	4c. County of De									
	Exami	ici		ive	Mitchellville	Prince G	eorge's								
	Funeral Director		377 20 3011	7. Age ( <i>In yrs. last birthday</i> ) M 2 <b>Q</b> F 95 Yrs.	Months Days Hours Min. 8. Days Hours Min. Se	onth, Day, Year)  pt. 10, 1912	rthplace (State or Foreign Country) Georgia								
-27	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits								
	Maryla f sho	tor	MD Prince G	eorge's Mitc	chellville		1⊠Yes 2□No								
	3a or 28a	Il Direc	10e. Street and Number 1400 Marco	Drive	10f. Zip Code 20721	10g. Citizen of What C United S									
9600	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "naturel", or Items 23a or 28a-f show any Injury or other traumatic event. I'm Modical Exertinal Experiment Exercities and once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	1 ☐ Yes 2-√ No	Vas Decedent of Hispanic Origin? (Specify Y i Yes, specify Cuban, Mexican, Puerto Rican, □ Yes 21 No Specify:	Specify: A									
5-0	natu	etec	15. Decedent's Edu (Specify only highest grade	cation 16a. Deced e completed) (Give	lent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business	s/Industry								
121	within ene. then	ld mc	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	Home Maker	Dom	estic								
d 2	Hygi other	0	17. Father's Name (First, Middle, Last)		1	, Middle, Maiden Surname)									
lan	Menta Menta rked tlc ev	To B	Walter J. Singl	eton	Bertha	Ford									
, Maryland 21215-0036	nd 2 shou lith and M 27 is mar r traumat		19a. Informant's Name/Relationship (Ty. Althea B. Watson /	1 400	g Address (Street and Number or Rural Rout Marco Drive, Mitchel		Zip Code) 721								
Baltimore,	Pages 1 and of He and: If Item		20a. Method of Disposition  1x Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	lemoval from State 20b. Place of Dispo- cemetery, crem Fort Linco	sition (Name of Date natory or other place) oln Cemetery 10/15/2	20c. Location - City of Brentwo									
Balti	permit. Departn Imports any Inju		21. Signature of Funeral Service License	/	Name and Address of Facility McGuir 400 Georgia Avenue, M										
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ications that caused the death. Do not ente	er the mode of dying, such as cardiac or resp	iratory arrest,	Approximate Interval Between								
	Physician /Medical Examiner	ı.	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	ardiovascular Heart l	Disease	Onset and Death								
	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):											
Ć,	tificate be executed ig physicien and as the burial-transit	Exar	Examiner	Exar	Ехаг	Ехаг	Ехаг	Exar	Exar	Exar	that initiated events resulting in death) Last	Due to (or as a consequence of):			
68760,	te be ysicie	ledical		J											
	ng ph a as th	Med	IF FEMALE:												
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Completed by Physician/M	2	ysiclan/N	ysiclan/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		Ectopic pregnancy Other (specify)	23d. Date of do Month	elivery Day Year					
	w requires that been signed b should be deta			Part II. Other significant conditions cor	ntributing to death but not resulting in the ur	nderlying cause given in Part I. 2	3e. Did tobacco use contribute 1 ☐ Yes 2 ☐ No 3 ☐ F	to the cause of death?  Probably 4 Dunknown							
Records,	The law rec sete has beer page 2 shou					autopsy prior to death?									
		0	25. Was case referred to medical		26. Place of Death (Che		s 2 No								
of Vital	d is	To B	examiner?	lospital: 1 Inpatient 2 ER/Outpatien	Othor	i Mesidence 6 □Other (Sp	ecify)								
ion o	Attending Phyric death.  ector: After thi by the funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Time of Injury Injury	28c. Injury at Work?  M 1 Yes 2 No	escribe how injury occurred									
Division	tal or Attendes: selter deatles Director: sel by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office 28f. Lc	ocation (Street and Number or F ity or Town, State)	Rural Route Number,								
	To the Hospital or Attending Ph within 24 hours efter death. To the Funerei Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Physical Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of my knowledge, death ner: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place, and durestigation, in my opinion, death occurred at t	ue to the cause(s) and manner a he time, date and place, and du	as stated. ue to the cause(s)								
	To the To the Comp	ž	29b. Signature and title of certifier	10 1	29c. License number	29d. Date signed (Mor	nth, Day, Year)								
	Ol		Samuelon	/ here so	H0055927	Octob	~ 17,200)								
			30. Name and address of person who co	mphied cause of death (Item 23a) (Type, I	Hospital Drine	- Closery	a Marylad								
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 6 20	32. gistrar's Signature	selle.	/									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year AM Physician REVI HOUSE Z007 C. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner University of Maryland Medical ctr Baltimore MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Hours Months Days 1 □ M 2 🕅 F Maryland 11-22-1955 Director 213-60-1122 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County a or 28a-f show t be notified at 1 ☐ Yes 2 X No Directo Anne Arundel Lothian Maryland | 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20711 5757 Solomons Island Rd. or Items 23a must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Informatir: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examiner any injury or other traumatic event, the Medical Examiner one. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: White Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Religious Priest 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peggy Jean Ripperger Charles Thomas House ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rev. William H. Ticknor/CoWorker5757 Solomons Island Rd., Lothian, MD 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10-12-07 Edgewater, MD Kalas Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Pure I Service Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** MO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o) as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome pf pregnancy
1 Live birth 2 Fetal dead
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 No 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 ☑ Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title/of dertifier 7525

State Registrar Samantha

31. Date filed (Month, Day, Year)

OCT 1 5 2007

DHMH 17 Rev 1/2001

South Greene St Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

32 Registrar's Signature

Wood

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10/4/2007 Physician 09:57 P M vanAlen Hollomon /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Kent Chestertown 7673 Quaker Neck Rd. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/2/1942 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 📈 2 🗆 F Min. 65 464-70-1193 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County X∏Yes 2 ☐ No Director Chestertown Kent 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21620 7673 Quaker Neck Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Architectural Consultant Architecture 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginius vanAlen Hollomon Nell Pettit P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7673 Quaker Neck Rd. Chestertown, MD 21620 Heidi Hollomon/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Cremation | 10/5/07 Stevensville,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fellows, Helfenhein&Newnam 21. Signal of Funeral Service License 130 Speer Rd. Chestertown, MD 21620 Approximate Interval Between Oaset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or comp shock, or hear failure. List only of Immediate Cause Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 1 Live birth 2 Fetal death Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death,

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 ER/Outpatient 3 □ DOA ၉ 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: (Month, Day Year) Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

45

Im

State

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day

Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

Signature

I 🕳 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

			1 - For State Registrar  1. Decedent's Name (First, Middle, I	State of Man	/land / Dep <i>Ce</i>	artment of rtificate of	Health and Death		eg. No.	3 4 8 1 5	
9	Physici	100	Cecilia	M.	Норе			Month	Day Ye	0640M	
	/Medic Examin		4a. Facility Name (If not institution, g		ENTER	4b. City, Town, SALIS	or Location of Deal	th	4c. County of I		
	Funeral Director		n/a	Sex 7. Age (1.1 1	n yrs. last birthday, Yrs.	Months Days				Birthplace (State or Foreign Country) rgentina	
	yland tow		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or L	ocation				10d. Inside City Limits	
	Ba-f et	ctor	Maryland Wicom	nico	Salisbury	У				1 🛛 Yes 2 🗆 No	
	with th	Funeral Director	10e. Street and Number 1018 Heron Cou	ert		10f. Zip Code 2180	7/1	1	og. Citizen of Wha Canad		
	ne 23	eral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.		Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No-	14. Race	American Indian,	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 le marked other then "naturel", or Iteme 23e or 28e-f ehow any injury or other treumatic event. The Medical Experiment inset by codifical at ODGE.	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cu  1 ☐ Yes 2 ⚠ No		to Rican, etc.)	Specify:	White, etc. white	
2-0	72 ho natur	eted	15. Decedent's (Specify only highest of		16a. Dece	edent's Usual Occu	ipation of during most of wo od)	orking	16b. Kind of Busin	ess/Industry	
121	within ane. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retir sewife	ed)		Domesti	C	
<b>d</b> 2	Hygie other	Be Co	17. Father's Name (First, Middle, La		11001	JCW11C	18. Mother's Na	me (First, Middle,			
/an	should be fand Mental be marked of	To B	Egbert Storm				Berth	e (unkr	nown)		
Σ	s 1 and 2 sho of Health and I Item 27 Ie ma other treum		19a. Informant's Name/Relationship Allan J. Hope/hu	1 21 1				lural Route Number lisbury,			
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3	1	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pl	ace)	Date	20c. Location - Cit	y or Town, State	
	t. Pag rtment rtent: njury o		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Unit	ci(y)	Salisbur			16/07	Salisbur		
Ba	Depa Impo		> Keet & V	leiney (F	10	501 Snow	Hill Rd.	, Salisbu	ury, MD 2		
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	ly one cause on each line.	FIZEBRA				rest,	Approximate Interval Between Onset and Death	
П	Examiner			Due to (or as a c	onsequence of):						
7	P =	ner	Sa pentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury								
	ate be executed thysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last  Due to (or as a consequence of):								
8760,	be ex	Ical E									
687	tificate ug phys	ed a		d.						11	
Box	death cer e attendir id for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ◯ No	23c. If yes, outcome of 1 □ Live birth 2 [ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pregnan □ Other (specify)	су		23d. Date o Month	f delivery Day Year	
P.0	that the de ed by the a detached		9 Unknown Part II. Dther significant condition		not resulting in the	underlying cause o	uven in Part I	23e. Did to	bacco usa contribu	ite to the cause of death?	
ds,	luires tha n signed ald be det	d by						1 🗆 Y	es 2 📈 o 3	☐ Probably 4 ☐ Unknown	
Records,	The law requires that the ste has been signed by th bage 2 should be detache	Completed						24a. Was a autop perfor	sy prio		
Vital		0	25. Was case referred to medical				26 Place of De	1 ☐ Yes eath (Check only or		Yes 2□ No	
Ž	S S	To B	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 npatient	2 ER/Outpatie	ent 3 DOA	thoc	Home 5 ☐ Resid		(Specify)	
ion of	ding h. After fune		27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investiga		28a. Date of Injury 28b. Time of Injury			28d. Describe h	28d. Describe how injury occurred		
Division	Dir	Certification:	3 Suicide 6 Could no 4 Homicide determin	286. Place of injury						or Rural Route Number,	
	ne Hospitel 24 hours in Funerel idetely filled	edical		Physician: To the best of reminer: On the basis of example and manner state	camination and/or is						
	To the I	Me	29b. Signature and little of certifier				nse number	i	29d. Date signed (i	Month, Day, Year)	
}			1118	MD		De	57331		10 14	07	
5	My		1	no completed cause of dear	th (Item 23a) (Type	Print)	reall st	Salis	hucu m	D. 21801	
	Sta		31. Date filed (Month, Day, Year)	2007 32. Tegistrar's	Signature	backs	110[[2]	. ~u115	bu. y, m.	D- 21801	
11.95	Regist	ar	00111	A MEHABA	o par fre						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Darian Hill Devon 2007 0827 October 10, /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KENINSULA REGIONAL MEDICAL ALISBURY Wicomico LONTER Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Hours Min 1**x** M 2□F Director 2 10/10/2007 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 XNo Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 715 Booth St. 21801 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married African/ 1 ☐ Yes 2 🔀 No Specify: þ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marvin Luther Hill Tamara Eleanor Lee 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 715 Booth St., Salisbury, MD 21801 Tamara Brooks/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 10/16/07 4 □ Donation 5 □ Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service Lice <sup>22</sup> Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 [annatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Director: After 5 Pending investigation 1 Natural 1 TYes 2 TNo death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division or Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

within 24 hours a To the Funeral C

State Registrar

Medical

29a. Certifier

and manner stated

29c. License number D 30050

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 10-10-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

indsay

DAlisbury, Md. egistrar's Signature

1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Jean /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deatl Examiner District Heights ppara If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, **Funeral** Days Hours Min. -11-Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 Yes 2 □ No Funeral Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA items Was Decedent Eyer in U.S Armed Forces?/ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Examiner 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married Baltimore, Maryland 21215-0036 0 2 No 1 ☐ Yes Specify ģ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Completed er than "nature the Medical E 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Many Injury or other traumatic event, the Monee. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P ina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) TiVE Btrict Jones Cha Pparal 7209 Heights Regina -Montgoner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 13/2007 Dunn NC Rest Haven Cemeter 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice pe Funeral Home 22. Name and Address of Facility 5538 Harlbaro Forestville Hd 20147 23a. Part1. Enter the disease, r omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Years /Medical Due to (or as a cons quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Closease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death been signed by the s 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an s certificate has b lirector, page 2 s autopsy performed' 1 Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) 1 Tyes 2 No Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 D Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) UD B 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 1. Date filed (Mor

DHMH 17 Rev 1/2001

te grass

MD

32. Registrar's Signature

Ba Himult

Registrar

			- FOI	partment of Health and I		- 1 - 1 -				
	_		1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg.	No2007 34819				
Е	Physicia	an	1. Decedent's Name (First, Wilder, Last)			Day Year M				
	/Medic		Bertha L. Johnson  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	October	9 2007 2:55 am 4c. County of Death				
7	Examin	C!	8195 Old Mill Road	Pasadena	Z	Anne Arundel				
6	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth (Month, Day, Ye	9 Birthplace (State or Foreign				
	Director		219-16-2275 1□M 2\F  89 Yrs.		Feb. 3 1	1918 Maryland				
	land ow It		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location		10d. Inside City Limits				
	Mary -f she fied a	tor	Maryland Anne Arundel Annapo:	is		1 ☐ Yes 2 📆 No				
	th the or 28a noti	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Country?				
	23a ust b		165 Brownswood Road	21401		USA				
	er deg	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S if Yes, specify Cuban, Mexican, Puert</li> </ol>	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.				
36	rs afte	by F	1 □ Never Married 2 □ Married 1 □ Yes 25 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Black				
Ş	2 hou atura cal E	ted	15. Decedent's Education 16a. Dec	cedent's Usual Occupation	, 16t	b. Kind of Business/Industry				
215	thin 7 e. an "n Medi	ple	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of wor . DO NOT use retired)	rking					
2	ed wi ygien <b>ier th</b> t, the	Completed	7th 0	Laundry Worke		s Naval Academy				
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Be	17. Father's Name ( <i>First, Middle, Last</i> )  Walter O. Porter		ne (First, Middle, Mai Che Griff	'				
3	s 1 and 2 should f Health and Men Item 27 Is marke other traumatic	은		illing Address (Street and Number or Ru						
<u>N</u>	and 2 sealth an n 27 is ier trau			55 Brownswood Ro						
ē,	es 1 and 2 of Health f Item 27 I		20a Method of Disposition 20b Place of Dis	position (Name of		c. Location - City or Town, State				
timore,	0 0		MDBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Church	enatory or other place) alavary U.M. Cemetery 10/1	13/07 Ar	cnold, Md.				
ā	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility						
<u> </u>	Pe a m Pe		Jany B. Agese MEGY83	Wm. Reese & Sor 821 West St. Ar	inapolis,	Md. 21401				
ı			23a. Pent1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death				
	Physician		immediate Cause (Final disease or condition resulting in death)  a.   Author							
	/Medical Examiner		Due to (or * nsequence of):							
		er	Sequentially list conditions, if any, leading to inmediate b.	Cance						
	outed id ansit	Examiner	Sequentially list conditions, if any, leading to limitediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ö,	e exe ian ar urial-t		resulting in death) Last Due to (or as a consequence of):							
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d							
9 X	death certific attending p	/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of delivery				
Box	atten after I for u	Physician/Me	in the past 12 months?	B⊟Ectopic pregnancy Doubler (specify)		Month Day Year				
o	t the c by the ached	nysi	9 ☐ Unknown 9 ☐ Unknown							
o, D	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?				
Records,	equire en sig ould b	edk			1 Tes	2 No 3 Probably 4 Unknown				
မင္ပ	e law ra has be je 2 sho	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of				
	The cate ha	Соп			performe 1□ Yes 2⊡	d? death? ∃No 1 □ Yes 2 □ No				
Vita	sician: Th certificate rector, paq	Be	25. Was case referred to medical examiner?  Hospital:		ath (Check only one)	e 6 Xother (Specify) Niece's				
	Phys	- To	1 Yes 2 No 1 Inpatient 2 ER/Outpat 27. Manny of Death 28a. Date of Injury 28b. Time	Tent 3 BOA 4 Nursing P	lome 5 Residence 28d. Describe how	or o Borner (openin)				
o	ding P th. : After : funera	tion	1  Natural 5  Pending (Month, Day Year) Injur 2  Accident investigation			,				
Division or	Atter	ifica	3 Suicide 6 Could not be 28e. Place of injury - At home, farm,	street, factory, office	28f. Location (Stree	et and Number or Rural Route Number,				
ă	tal or s afte al Dir ed in	Certification:	4 Homicide building, etc. (Specify)  City or Town, State)							
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.		29a. Certifier (Check only (C							
	thin 2 the or the ormplet	Medical	one) and manner stated.  29b. Signature and title of certifler	29c. License number	29d	. Date signed (Month, Day, Year)				
	- M T W		Cata Hann M	0 05330	16	10/9/07				
4	Solv		30. Name and address of person who completed cause of death (Item 23a) (Type	e. Print)		26901				
•	10		Curtis Harris, MD 900	n n 5330 e. Print) Bestsate Rd	Ste 300	Annapolis MD				
	Sta		31. Date filed (Month, Day, Year) 32. registrar's Signature	land.						
	Registr	ar	OCT 1 5 2007 Street St	JOBACU .						

Amend #31, CCHD, 10/1	L6	per Registrar, 5/07, drw Please Type or Print in Black	( Ind	elible l	nk.	Ensi	ıre All	Copies	Are	Legible	e.	
	1	For State of Maryland / D	epar	tment d ificate	חוט	eaith	and ivie	ntai Hy	giene Reg. No	,	7 34	820
Physician	_	1. Decedent's Name (First, Middle, Last)  Carol Ann Jacob						. Date of Dea Month	Da	y Ye	3. Time o	Death
/Medical	ŀ	4a. Facility Name (If not institution, give street and number)		4b. City, To	wn or	Location		Octobe		5, 200		4 A <sup>™</sup>
Examiner		9185 Megatha Lane		10. 0.1,, 10		ings	01 2001				lvert	
Funeral Director		211-04-0011		If Under 1 Months E		If Under Hours	Min.	Date of Birt (Month, Day	y, Year)	9.	Birthplace (State Country) Ohio	or Foreign
f show		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town           MD         Calvert         Ow	or Loca								10d. Inside C	City Limits
ifter death with the Mar ritems 23a or 28a-f si iner must be notified Funeral Director	-	10e. Street and Number	1118	10f. Zip Co	ode		<u> </u>		10g. Cit	izen of Wha	it Country?	
th with	3	9185 Megatha Lane			20	0736					USA	
r deat		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Wa	as Deceder Yes, specify	nt of Hi	spanic Or n, Mexica	igin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)			American Indian, White, etc.	
0036 hours afteural, or it	2	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Yes 2		Specify			405-16	_,	White	
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. To fleatth and Mental Hygiene and Mental Hygiene. To the mz 71 sh marked other than "natural", or items 23a or 28a-f show or other traumatic event, the M dical Examiner must be notified at To Be Completed by Funeral Director	-	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  5+	(Give kir life. DC	nt's Usual ( nd of work ( ) NOT use i nance	done d retired,	luring mos )	st of working		Pri	nce Ge	ess/Industry eorge <sup>†</sup> s overnmen t	
ind 2 be filed tal Hygi d other event, ti	5  -	17. Father's Name (First, Middle, Last)		<u>rance</u>				First, Middle,			over innerio	
ylar ylar ould be Menta arked artic ev		Robert Dean Irwin				Je	ean E	lizabe	eth	Hall		
lary 2 sho 1 and 1 1s me	ı	T . T								or Town, Sta	ate, Zip Code)	
(1)	-							gs, MC		0736_	y or Town, State	
mor ages ant of t: If Ik		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State			er place	e) :	Oct 1 2007	6		linton		
Baltimore, permit. Pages 1 a Department of Hee important: If them any injury or othe	ŀ	4 □ Donation 5 □ Other ( <i>Specify</i> ) Lee C  21. Signature of Faneral Service Licensee			Addres	s of Facil		Funer			Calvert,	PΔ
Ball permit Depar Impor	ł	Gary J. Goff						nd Blv		owings		736
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a.					cardiac or i		rrest,		Approxima Interval Be Onset and	etween Death
/Medical Examiner		resulting in death)  Due to (or as a consequence of	of):	,								
<u> </u>		Sequentially list conditions, if any Lee Inglu immediate.  b. Due to for as a consequence of	of):									
xecuted and Il-transit	ľ	Cause. Enter Underlying Cause (Disease or injury that initiated events  c.										
e exercian ar urial-ti	Ì	resulting in death) Last Due to (or as a consequence of	rf):									
68760, ifficate be expression as the burian edical E		d								-		
oertific		IF FEMALE: 23c. If yes, outcome pf pregnancy								00d D-t-	f delices	
I Records, P.O. Box 68760,  The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit completed by Physician/Medical Examin		23b. Was decedent pregnant in the past 12 moaths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ctopic preg Other <i>(spe</i> c						23d. Date o Month		Year
Or Vital Records, P Physician: The law requires that r this certificate has been signed b ral director, page 2 should be deta		Part II. Other significant conditions contributing to death but not resulting in	the unde	erlying cau	se give	en in Part	l.				ite to the cause of	
al Record  The law requir cate has been si page 2 should I								24a. Was		24b. We	re autopsy findings r to completion of	available
The Is te has age 2								autor perfo	rmed?_	. dea	r to completion of ≀th?  Yes 2□ No	cause of
Vitalician:		25. Was case referred to medical examiner?			_		e of Death (	Check only o				
or Vita Physician: this certific ral director,	1	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	<u>.                                      </u>		Othe			5 ⊟ Resi				
ding F		1 ☑ Natural 5 ☐ Pending (Month, Day Year) Ir	Time of njury	M 28c	Injury Work	/at ⟨? Yes 2□	1	d. Describe l	now inju	ry occurred		
Division  I or Attending after death. Director: After Jin by the fune		3 Suicide 6 Could not be 28e. Place of injury ⋅ At home, far	rm, stree			(65 2		f. Location (	Street a	nd Number	or Rural Route Nu	mber,
Division of tall or attending F attendents rs after death. Tall Director: After led in by the funer. Certification:		4 ☐ Homicide determined building, etc. (Specify)						City or Tov	vn, Stat	e)		
Division or Vital Recutor to the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.  Medical Certification: To Be Compl		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and and manner stated.										(s)
To the within To the comp		29b. Signature and title of certifier				number			29d. Da	ate signed (/	Month, Day, Year)	
		· Cum			D29	9657			15	116	2007	
drw 10		30. Name and address of person who completed cause of death (Item 23a) (Charles Judge, MD 110 Hospital			ince	e Fre	ederic	k, MD	200	678		
State Registrar	-	31. Date filed (Month, Day, Year) 1 6 2007	K.	Spen	K	4						

State of Maryland / Department of Health and Mental Hygiens 34821 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** Harold William Kendrick, Sr. 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1037 W. Irvin Avenue Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 219-12-0715 82 08/03/1925 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it a Medical Exemines must be notified at 10a. State 10b. County 1 Yes 2 No MD Washington Hagerstown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21742 US 1037 W. Irvin Avenue Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Manufacturing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Cleatus Oliver Kendrick Mary Jane Taylor 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State. Zip Code, 1037 W. Irvin Avenue, Hagerstown, MD 21742 19a. Informant's Name/Relationship (Type, Print)
Kathy D. Jones, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 10/22/2007 Harerstown, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tomo **Physician** MON /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine use as the burial-transit ted by the attending physician and deteched for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown certificate has been signed by irector, page 2 should be detect 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Xes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \times \) Yes \( 2 \times \) No or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 4 ☐ Nursing Home 5 ➤ Hesidence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Injury Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation M 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitei 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name a dyaddress of person who completed cause of death (Item 23a) (Type, Print) Hagerstown, MD 21 WH 11+1 our 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Kendall 5r. Xtober 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Washington

5. Social Security Number Hospital Co 9. Birthplace Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year, 6. Sex **Funeral** Days Min. 1 M 2 □ F Months Hours 164-30-4851 68 79-**Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No erstown lag **Funeral Director** MD MAShins 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21742 U.S. A. 20229 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Yes, Give 'ear or Dates: Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) construction Elementary/Secondary (0-12) College (1-4or 5+) onstruction 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be valle Kendal1 Abercrombie ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) eserstown mD 20c. Location - City or Town, State Wayside Wayne Lendal Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition mcCbg, PA 1 Number 1 Description 1 Number 1 Numb 3 □Removal from State 10-21-07 Union 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 7014 Paint. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final N RK **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit hosco Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) □Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes Division or Vital 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manne Death 28a. Date of Injury (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and titt

SH-511

State Registrar 31. Date filed (Month.

Projetrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Klemmer ai 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Wicomico Salisbury If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number **Funeral** Year) Days 1 ☐ M 2 👿 F Pennsylvania 115-42-3566 4-12-1951 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits items 23a or 28a-f show Examiner must be notified at 1 □Yes 2KINo Maryland Worcester Newark Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21841 8421 Langmaid Rd. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 0, 1 ☐ Yes 2 🗷 No Specify: Š 3 ☐ Widowed 4 ☐ Divorced White "natural", Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4+ Interior Design Designer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any lipiry or other traumatic event once. Be Mary McGovern Charles Klemmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8421 Langmaid Rd. Newark, MD 21841 Jill Klemmer Schline-sister 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Anatomy Gifts Registry 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ADonation 5 ☐ Other (Specify) 10/17/07 Glen Burnie, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Holloway Funeral Home PA att 501 Snow Hill Rd. Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician etastat/L /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) □Yes 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 🗌 Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗆 Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: To the income after death. Within 24 hours after death. To the Funeral Director: After this come after this come after this come after the 1 Inpatient 2 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Manner of leath Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month.

DHMH 17 Rev 1/2001

W

PO BOX 1733

Salish MD 21802

Name and address of person who completed cause of death (Item 23a) (Type, Print)

OQ5

Registrar's

MS

Count

		4	For State Registrar	State of I	Maryland / D	epartmen Certificate			nd Men		ene g. N2 0 0 7	34824
ı	Physicia	an	1. Decedent's Name (First, Middle,	Last)						Date of Death Month	Day Ye	3. Time of Death
	/Medic	al			Carter La					ctober	25 2007	0703 A <sup>M</sup>
	Examin	er	4a. Fecility Name (If not institution,			,	Town, or Lo		Death		4c. County of D	
			Calvert Manor F		Center Age (In yrs. last birt		sing S	Sun If Under 2	24 Hrs.   8.1	Date of Birth	Ceci1	Birthplace (State or Foreign
	Funeral Director		202-18-9361	1□M 2∏F		rs. Months	Days I	Hours	Min. (	Month, Day,	Year)	Country) ennsylvania
	D		Usuel Residence of Decedent						1,51	30 7 , 3		
	arylar show	-	10a. State 10b. County		10c. City, Towr	or Location						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f	ecto	Maryland Ceci	.1	E1kto					4.0	0.00	
	with t	Funeral Director	10e. Street and Number	_ 3		10f. Zip				10	g. Citizen of What	
	eath	erai	323 Ed Moore Ro	12. Was Decede	ent Ever in U.S.	13. Was Deced	1921	anic Orig	in? (Specify	Yes or No-	United 14. Race - A	merican Indian,
(0	r Hen	Fun	1 ☐ Never Married 2 ☐ Marrie	Armed Force	es? [☑] No	If Yes, spec	cify Cuban, !	Mexican,	Puèrto Rica	ın, etc.)		/hite, etc.
8	72 hours after death with the Maryland natural', or flems 23a or 28a-f show ideal Examinator wat be notified at	by	3   Widowed 4 □ Divorced	If Yes, Give Year or Date		1 🗆 Yes	2tx No S	Specify:			Specify:	Vhite
21215-0036	72 h	Completed	15. Decedent's (Specify only highest	s Education grade completed)	16a.	Decedent's Usua (Give kind of wo	rk done duri	on ring most	of working	1	6b. Kind of Busine	ss/Industry
12	e filed within all Hygiene. I other than vent, the Mar	шp	Elementary/Secondary (0-12)	College (1-4	or 5+)	Cook	se retired)				Food Se	ruico
0 0	filed v Hygie ther t		17. Father's Name (First, Middle, L	ast)		COOK	18	8. Mother	r's Name (Fi	rst, Middle, M	aiden Sumame)	TVICE
au	ould be Mental Marked o	To Be	Samuel McCarter				1		Faddi			
ary	2 should be and Mental is marked surnatic ev	ř	19a. Informant's Name/Relationshi		19b.	Mailing Address					City or Town, Stat	e, Zip Code)
Σ	1 and 2 Health a tam 27 is		Sandi K. Foulk/	Daughter	32	3 Ed Mo	ore Ro	oad,	E1kto	n, Mar	yland 21	921
ore	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examirer is ast be notified at	1 3	20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal from St	20b. Place of cemeter	Disposition (Nar y, crematory or o ndon	ne of ther place)	00	ctober		New Lond	
Ë	Pag Iment tant: jury c		*4 ☐ Donation 5 ☐ Other (Sp.	ecify)	Presby	terian C	emetei	ry IZU	007		Pennsylv	ania
Baltimore, Maryland	permit. Pages 1 an Department of Heal Important: If itam 2 any njury or other QDGs.		21. Signature of Funeral Service L	S. Le	ehs	Hicks I	d Address of Home f Stock	of Facility For F kton	unera Stree	ls, P. t, Elk	A. ton, Mar	yland 21921
II.			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cau only one cause on eac	sed the death. Do r	ot enter the mod	le of dying, s	such as o	cardiac or re	spiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a A	cute 1	NYDCAT	-dial	1 7	- nfo	enction	OO	1 day
F	/Medical Examiner		rooding in doday	Due to (or	as a consequence							(Howassack
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or	A CONSequence		THEY	205	CLED	0515		years
d.	cate be executed obysician and the burial-transit	Examine	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
0	an an rial-tr											
8760,	ate be hysicii he bu	dicai	•	d								-
9	entific ling pl	Med	IF FEMALE:	00-14				_				
Вох	death certificate be executed e attending physician and of for use as the bunat-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?		me or pregnancy h 2 DFetal death nt at time of death	3 ☐ Ectopic po					23d. Date of Month	delivery Day Year
o.		ıysic	1 Yes 2 Too 9 Unknown	9□ Unknow		3 Cities (Sp	ecity/			E4-11-		
٩.	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant condition	ns contributing to deal	th but not resulting in	the underlying o	ause given i	in Part I.		23e. Did tob	acco use contribut	e to the cause of death?
rds	w requires that been signed b should be deta		Diabet	es Me	ellitus,	Type ]	I			1 ☐ Ye	s 2 <b>)27</b> yo 3⊑	Probably 4 Unknown
Vital Records,	aw re	Completed	Conges	tivo Co	indiama	2 path	u		-	24a. Was an		autopsy findings available to completion of cause of
Ä	0 - 0	mo:	3-				7			perform	ed? deat	h? Yes 2 No
ita	ysician: This contificate director, pag	Be C	25. Was case referred to medical examiner?				2	26. Place	of Death (C	heck only one	9)	
	S S S	2	1 ☐ Yes 2	Hospital: 1  Inp				4 Jur			nce 6 Other (	Specify)
Division of	tanding Pheath. tor: After the	lon:	27. Manner of Death 1 Natural 5 ☐ Pending			ime of a njury M	28c. Injury at Work?	ıt.' ıs 2∐N	1	Describe ho	w injury occurred	
<u>:</u>	t or Attanding after death. Diractor: After in by the fune	icat	2 Accident investigated as Suicide 6 Could not	ot be	I Injury - At home, fa			15 2 1		Location (Str	eet and Number o	r Rural Route Number,
<u>S</u>	i ji te	Certification;							City or Town			
	To the Hospital or At within 24 hours after d To the Funeral Diract completely filled in by	-53	29a. Certifier 1 Certifying	Physician: To the b	est of my knowledge	, death occurred	at the time,	, date and	d place, and	due to the ca	use(s) and manne	r as stated.
	the Hi in 24 tha Fu	edica	one)	xaminer: On the bas and manne					n occurred a			
	with To t	Σ	29b. Signature and title of certifier	$\sim$			c. License n			29	d. Date signed (M	Ionth, Day, Year)
•	, , , ,	11	W 4 1 C=	al al			DOD	- K	354		IM321	2.3
	, , , ,		My Z.	done			000	10 C	00 1		10/20/	1-
	3		30. Name and address of person w	who completed cause	1-	Type, Print)	000			5	ma	1101
	3	ıte.	DEIL E. LATTI	N, MQ	JOL Co	Type, Print)	المعرا		Risin	g Su	" We	71911
			DEIL E. LATTI	N, MQ	JOL Co	Type, Print)	_لهمر			g Su	n, me	71911

State of Maryland / Department of Health and Mental Hygiene, State Registrar AMEND#10c, 10e, 10fperFH10/16/07, PM, Actificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ам 7:05 October 0 05, 2007 Wen-Yuan Lee /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Silver Spring Sadanand Home II Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 1 M 2 F 89 Oct. 11 China Director 577-54-1393 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at Potomac Silver 1 ☐ Yes 2 X No Directo Maryland Montgomery the 10g. Citizen of What Country? 10f. Zip Code 20854 10e. Street and Number ral", or items 23a or Examiner must be r Place Pages 1 and 2 should be filed within 72 hours after death with Kim United States Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2K No Specify: Baltimore, Maryland 21215-0036 Specify: δ 3 ☑ Widowed 4 ☐ Divorced Asian "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation h and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Attorney Legal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ping Chen Chun Tong Wei ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any Injury or other tra 11820 Kim Place, Potomac, Maryland Colleen Wei / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Ft. Lincoln Crematory 10/17/2007 | Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Simple Tribute Rockville, Maryland 20852 1040 Rockville Pike, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Alzheimer's Disease /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves. outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 🔀 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2XINo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 🔀 No Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient Other:  ${}_{4}\square$  Nursing Home  ${}_{5}\square$  Residence  ${}_{6}$  QOther (Specify) Group Home 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Certification: To After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 2 D64615 10/11/2007 age 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wroblenski, M.D. 1355 Piccard Drive, Rockville, Maryland 20850 32. gistrar's Signature 31. Date filed (Month, Day, Year) State 2001 16 Registrar OCT

State of Maryland / Department of Health and Mental Hygien 🗲 U U /

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day OCTOBER 9,  $\mathbf{P}^{\mathsf{M}}$ **Physician** LUDD 2007 2:05 CLIFTON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges 1204 Boones Hill Rd. Apt# 1 Capitol Heights If Under 1 Year If Under 24 H 8. Date of Birth (Month, Day, Year) 3/15/1920 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Davs 1**₩**M 2□ F Yrs. 577-16-9841 87 Pinewood, Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10h County 10c. City, Town or Location ir then "naturel", or itema 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2X No Capitol Heights Md. Prince Georges Director 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number 1204 Boones Hill Rd. Apt# 1 20743 U.S.A. deeth Funeral 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after deet Department of Health and Mental Hygiene. Important: if item 27 is marked other the any injury or other transmitted. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married black Specify: 1 ☐ Yes 2X No Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Capitol Cab Company Elementary/Secondary (0-12) College (1-4or 5+) Taxi Cab Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lillie Harvin Joseph Ludd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip CodeMd • 20743 19a. Informant's Name/Relationship (Type, Print) 1204 Boones Hill Rd. Apt#1 Capitol Heights, Alberta Ludd/ wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Cheltenham VA Cem. 10/16/07 Cheltenham, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Universal Mortuary 21. Signature of Funeral Serving Licenses 411 Kennedy St., N.W. Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physicien and for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physiclan/Medical IE FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 Yes 2 No 3 Probably 4 ₩Unknown Be Completed peed 24b. Were autopsy lindings available prior to completion of cause of death?
1 ☐ Yes 2 【■No 24a. Was an autopsy performed? Yes 2. No 1□ Yes After this certific funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie OCTOBER 10, 2007 MD# 33255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAREN ANN BLACKSTONE, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 32. Registrar's Signature 31. Date liled (Month, Day, Year) OCT 1 5 2007 State Registra

Physicia /Medic Examin	al
Funeral	

			For State Registrar	State of Mary		artment of H tificate of I			iene ZU ( eg. No.	) [	34021
			Decedent's Name (First, Middle, Last)			· · · · · · · · · · · · · · · · · · ·		2. Date of Deat Month	h	'ear	3. Time of Death
	Physici /Medio		Mary Catherine LU	M				October			9:15 a. M
1	Examin		4a. Facility Name (If not institution, give s	reet and number)		4b. City, Town, or	Location of Death	1	4c. County of	Death	
			12913 Salem Avenu			Hagers				ning	
	Funeral		5. Social Security Number 6. Sex	14 0075	n yrs. last birthday) 1 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Count	ace (State or Foreign
	Director		718-09-1091	M 25XF 8:	L 113.			Oct. 17	, 1925	Mar	yland
	land w		10a. State 10b. County	10	c. City, Town or Lo	cation				10	d. Inside City Limits
	Mary	ţo	Maryland Washing	ton		Hagersto	√n				1 ☐ Yes 2 X No
	r 28a	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	at Count	ry?
	7 wit	aiΩ	12913 Salem Avenu	e		2	1740		USA		
	deal	Funeral Director	11. Marital Status	2. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Black,	America White, e	
98	or its	J. T.	1 Never Married 2 Married	1 ☐ Yes 2 📉 No If Yes, Give	1	1 ☐ Yes 21 No			Specify:		ite
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28a-f show lited Exacilinat musi be notified at	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:	160 Dece	test's Havel Ossus	ation	-	16b. Kind of Busi	necs/Ind	uetry
15	n 72	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occup: kind of work done o DO NOT use retired	ation during most of wor f)	king	160. Killa of oasi	11055/1110	ustry
12	within iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		retary			railro	oad	
	should be filed withir and Mental Hygiene. marked other than imatic event, to ha	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, I	Maiden Sumame,	1	
<u>a</u>	Mental Mental rked o	To B	John William Shup	p			Mazie	Ann Moc	re		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic seent, the Medical Exercities must be notified at	-	19a. Informant's Name/Relationship (Type	e, Print)	i	ng Address (Street			-		
	and 2 ealth n 27 i		Mary L. Martin - d			5 Hollowe	11 Churc	The state of the s			
ore	iges 1 nt of He in their or oth		20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Re	1	•	natory or other plac			20c. Location - C	•	
Ë	Pages ment of I tant: If Its jury or o		4 ☐ Donation 5 ☐ Other (Specify)			en Cemete		/18/07			Maryland
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tr. once.		21. Signature of Funeral Service License	n m	/ /	2. Name and Addres					217/0
	<u>v</u> ∪ = • o		cour	11 Kinn		15 E. Wil				1d. 2	21740 Approximate
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.	e death. Do not ent	er the mode or dyin	g, such as cardiad	or respiratory arr	est,		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Small C		noma of	Xuna	7		ধ	nonths
1	Examiner			Due to (or as a c	onsequence of):		0 (	7			
		e.	Securities ly list conditions bif any, leading to immediate	Due to (or as a c	onsequence of):						
	uted d ansit	edical Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events								
ó	icate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to (or as a c	onsequence of):						
68760,	ite be iysicië ne bu	cai								_	
	rtifica ng ph		IF FEMALE:				-81-5			- 1	
Вох	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐	Fetal death 3	Ectopic pregnancy	,		23d. Date Mont		ry Day Year
	e dea the at	sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□ Pregnant at tim 9□ Unknown	e of death 5	Other (specify)					
P.0	hat the deby	P.	Part II. Other significant conditions con	tributing to death but r	not resulting in the u	nderiving cause giv	en in Part I.	23e. Did to	bacco use contrit	oute to th	e cause of death?
ds,	ires that signed t d be det	d b	Hypertension		•	, ,		1 🗆 Y	es 2□No 3	Proba	ably 4 Winknown
Ö	w requir been si should	ete	14 1 1 1					24a. Was a	24h W	ere autor	osy findings available
Re	0 - 9	d H	myper ipiciem	, ca				autops perfor	med?/ de	or to con ath?	npletion of cause of
7	n: Ti ficate or. pa	ပိ	25. Was case referred to medical				OF Blood of Dec	1 ☐ Yes ath (Check only or		Yes	2∐ No
of Vital Records,	Physicien: The lavithis certificate has al director, page 2	To B	examiner?	ospital:	2 ER/Outpatie	nt 3 DOA Oth		lome 5 Resid		(Specify	<i>(</i> )
of	Attending Physician: r death. ector: After this certific by the funeral director.		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time o				ow injury occurre		,
0	ath. rr: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(World), Say	om/ Injury		Yes 2 □No				
Division	r Atte	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (		reet, factory, office		28f. Location (S City or Tow	treet and Numbern, State)	r or Rura	I Route Number,
	ital or irs afte rat Dire										
	To the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral of	edicai	(Check only 2 Medical Examin	ician: To the best of reer: On the basis of ex	amination and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	e, and due to the c arred at the time, c	ause(s) and man late and place, ar	ner as st nd due to	ated. the cause(s)
	To the l within 2 To the I	Med	one) 29b. Signature and title of certifier	and manner stated	J.	29c. Licens	e number		29d. Date signed	(Month.	Day, Year)
	M. T. O.		17/18	11			3810		2 Lakar	17	
			20 Name and address of a sea units	moleted cause of days	h (Item 23a) (Tun-	-	0010		~C100CK	' +	2007
61	H-4		30. Name and address of person who co				3 HAG	SERSTON	am u	21	740
		ate	31. Date filed (Month, Day, Year)	32. Registrar's					- 1	-	

DHMH 17 Rev 1/2001

State

Registrar

OCT 17 2007

			1 - For State	State of Ma	aryland / Dep	artmen e <i>rtificat</i>	t of He	ealth and N			007	34828
			Registrar  1. Decedent's Name (First, Middle, La	st)		) timout	0 01 2	- Cutiii	2. Date of De			3. Time of Death
ı	Physicia		Samuel Crowley Lo	oveland, J	r.				10/1	1/200	Year 7	2150 P M
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City,	Town, or	Location of Death			ounty of Death	
			Heron Point			Ches	tert	own		1	Kent	
	Funeral		Social Security Number     6. S	ex 7. Age	e (In yrs. last birthda	/) If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 07/22	th ay, Year)	9. Birth Cou	place (State or Foreign ntry)
	Director		163-03-2400 Usual Residence of Decedent		97 Yrs.				07/22	/1910		NJ
	/land		10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits
	Man.	tor	MD Kent		Cheste	rtown						1 XYes 2 No
	th the or 284	Director	10e. Street and Number			10f. Zip	Code			10g. Citize	n of What Cou	ntry?
	23a		134 Heron Point				2162	0		1	USA	
	r de	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?	1	. Was Deced	dent of His	panic Origin? (Sp., Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14	<ul> <li>Race - Ameri</li> <li>Black, White</li> </ul>	
36	s afte	<b>by</b> Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 201	10	1 🗆 Yes	No No	Specify:		S	pecify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Examinar must be motified at	ed k	15. Decedent's E	Year or Dates:	16a Dec	edent's Usua	al Occupa	tion	·	16b Kind	of Business/Ir	ndustry
75	nin 72 nin nin	Completed	(Specify only highest gra Elementary/Secondary (0-12)		(Gir	e kind of wo DO NOT us	rk done di	uring most of worl	king			,
2	giene giene er the	mo:	12	4	'	ine Tr	ansp	ortation		Tra	nsporta	tion
밀	al Hy d oth	Be (	17. Father's Name (First, Middle, Last,					18. Mother's Nam			ımame)	
Уa	outd b Ment Market	2	Samuel C. Lovelan						de Smit			
Baltimore, Maryland	nd 2 sh Ith and 27 is n r treum		19a. Informant's Name/Relationship ( Doris Loveland/wi			•		nd Number or Ru nt Chest				o Code)
ore,	ss 1 ar of Hea item		20a. Method of Disposition	10 11 0	20b. Place of Dis	position (Nan			Date	20c. Loca	tion - City or T	own, State
<u><u>Ĕ</u></u>	Page		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif		Chesapea	ke Cre	mati	on 10/1			nsville	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinating must be notified at once.		21. Signature of Funeral Service Licer	refli				of Facility ${ m Fe}$ Rd. ${ m Ches}$				Newnam
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not e	nter the mod	e of dying	, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
n	Physician	ř	Immediate Cause (Final disease or condition	ASPU	ZATION	ME	um	AIM				Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):	•						
	Examiner	_	Sequentially list conditions,	b								
	bed tist	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):							
	ad-trai	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):							
58760,	icate be executed physician and s the burial-transit	edicai E		d.								
_	rtifica ng ph		IF FEMALE:									
Вох	death certific attending pl	an/N	23b. Was decedent pregnant	23c. If yes, outcome 1☐Live birth		□Ectopic pr	egnancy			230	d. Date of deliv	•
0.	The law requires that the death certif tie has been signed by the attending bage 2 should be detached for use as	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (sp	ecify)				Month	Day Year
<u>a</u>	res that tigned by	y Ph	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlying c	ause givei	n in Part I.	23e. Did t	tobacco use	contribute to t	the cause of death?
Records,	w requires been sign should be	ed by							1 🗆	Yes 22	No 3□Pro	bably 4 ∐Unknown
900	ne law requ has been ge 2 shouli	Completed				_			24a. Was		24b. Were auto	opsy findings available ompletion of cause of
œ.		Com							perfo	ormed?	death? 1 ☐ Yes	2 <del>2</del> %
Vital	icien: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o	one)		
5	Physic this c	٩	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie				4 ☐ Nursing H	ome 5 Resi			fy)
Division of	ding Physicien: The n. After this certificate hi funeral director, page	ion	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injui (Month, Day	Year) 28b. Time Injury	of 2	8c. Injury Work	at ? es 2 □ No	28d. Describe	how injury o	occurred	
<u>s</u>	or Attending Physicien: ther death. Director: Atter this certific in by the funeral director.	ficat	2 Accident investigation 3 Suicide 6 Could not b		ury - At home, farm,			92 5 140	28f. Location /	Street and I	Number or Run	al Route Number.
<u>≤</u>	el or A s after al Dire	Certification;	4 Homicide determined	building, etc	c. (Specify)	moot, idetory	, 011100		City or To			
	To the Hospitel or Attenwithin 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best on niner: On the basis of	of my knowledge, de	ith occurred	at the time	e, date and place,	and due to the	cause(s) ar	nd manner as s	stated.
	the F hin 24 the F mplete	Medicai	one)	and manner sta	led.							
	To To		29b. Signature and title of certifier	.04		290	. License				signed (Month,	
	24		20 Alime and address of	Sampleted and	noth (las = 00 ) CT	O=i=*\	7	06030	7)	(0)	17/0	/
	BAE		30. Name and address of person who	A Mon	eath (Item 23a) (Type	Print)	Sles	n PD	CBA	ST ZZ	nou	N, M)
	Sta	-011	31. Date filed (Month, Day, Year)		ar's Signature	ella a						
	Registr	ar	OCT 15 2007		65° 6	Carlo Carlo						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 03:01A M 10/07/2007 William John Lauman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6535 Rock Hall Rd. Kent Rock Hall if Under 1 Year | If Under 24 Hrs 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days (Month, Day, Year) 11/20/1947 Months Hours 59 176-38-8723 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County MDKent Rock Hall 1XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 21661 USA 6535 Rock Hall Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 6.7 € 0.0 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No White Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: 67–69 Specify: þ 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinest Machine Shop 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Lauman Helen Rose Reeves Bergey ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiffany Walls/Daughter 6191 Dorlon Dr. Rock Hall, MD 21661 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Cremation | 10/10/07 Stevensville,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fellows, Helfenbein & Newnam 21. Signature of Funeral Service Licensee 130 Speer Rd. Chestertown, MD 21620 23a. Part1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -IVER FAILURG Physician /Medical Due to (or as a consequence of): Examiner CIRKHOSIS Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performe 2 No certificate | 2 No director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 2 ER/Outpatient 3 DOA 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No neral Director: A filled in by the for 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

30. Name and addre

Jennite (
31. Date filed (Month, Day,

of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

2007

ARosa

H0062423

6602 Churchhill Road Chestertoun, MD 21620

			For State Registrar	State o	f Maryla	nd / Depa	artment	of He	ealth a	and M		Reg. No.	07	34830
*	Physici /Medic	- 10	Decedent's Name (First, Middle     Jackson	e, Last)	F.		Laws	5			2. Date of Dea Month October	Day	Year 2007	3. Time of Death 10.57 M
	Examin		4a. Facility Name (If not institution	, give street and nur	nber)	<i>a</i> ,	4b. City,	Town, or	Location o	of Death			ity of Death	
			PANINSULA REGION		04/ 1	enter		3411.	sburg				COMICO	
	Funeral Director		5. Social Security Number 215-12-6496	6. Sex / 1 M 2 □ F	7. Age (In yrs	. last birthday) Yrs.	If Under Months	1 Year Days	Hours	24 Hrs. Min.	8. Date of Birt (Month, Da) 9-2-19	h v. Year) 24	9. Birthp Coun Mary	
	show ad at	or	Usual Residence of Decedent           10a. State         10b. County           MD         Wicom:	: a.a		ity, Town or Lo							1	0d. Inside City Limits 1X Yes 2 □ No
	28a-	Director	MD Wicom:	160	) ba	lisbur	10f. Zip	Code				10g. Citizen o	f What Coun	itry?
	3a or		1700 Woodholme	Court				21804	<u>'</u>			USA		
92	permit. Pages 1 and 2 should be tiled within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at once.	y Funeral	11. Marital Status 1 □ Never Married 2 ☒ Marr	12. Was Dece Armed Fo 1 X Yes	2□No 19	42-		lent of His of Cubar		gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	8	ace - Americ lack, White, Cify: Whit	etc.
Maryland 21215-0036	ural',	d by	3 Widowed 4 Divorced	Year or D	ates: 19	46			tion					
7	"nat	Completed	15. Deceden (Specify only highe	t's Education st grade completed)		(Give	dent's Usua kind of wor DO NOT us	k done d	uring mos	t of worki	ing	16b. Kind of	Business/inc	dustry
2	within than	m C	Elementary/Secondary (0-12)	College (1	I-4or 5+)	Region				tor		State	of Mar	vland
2	Hygi other	Be C	17. Father's Name (First, Middle,			1200					e (First, Middle,		-	
<u>a</u>	Mental Mental Med	To B	W. Ernest Laws						Mary	Mar	vi1			
ary	e ma	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address	(Street a	nd Numbe	er or Rura	al Route Numbe	er, City or Tow	m, State, Zip	Code)
Σ	and 2 saith a n 27 i		D. Jean Laws -	wife					Cour		alisbur			
ore	of He of Her		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □ Bemoval from	1	Place of Dispo cemetery, crea	osition (Nan matory or o	ne of ther place	9)		Date	20c. Location	n - City or To	wn, State
<u>Ĕ</u>	Pag ment ant: h		4 Donation 5 Other (S			rsons					6-2007	Salisb	ury, N	Maryland
Baltimore,	permit. Departi Importi any Inj once.		21. Signature of Funeral Service	Licensee	00 10	2:	2. Name an	d Addres	s of Facilit	<sup>ty</sup> Bo	unds Fu	neral	Home	
	20E # 9		23a. Part1. Enter the disease, or	Dung &	Hare								arylar	nd Z1804 Approximate
	Physician /Medical Examiner e prijal-transit	Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, lary, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a. Rev Due to b	(or as a conse	equange of jr	lav	e						Interval Between Onset and Death
68760,		dical		d.										
P.O. Box 6	The law requires that the death certiticate be executed the has been signed by the ettending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		ointh 2 ☐ Fe nant at time of	tal death 3[	Ectopic pr Other (sp						Date of delive Month	ery Day Year
rds, P	w requires that been signed b should be deta	ed by Pł	Part II. Other significant condition	ons contributing to d	eath but not re		inderlying c	ause give	n in Part I		23e. Did t		_	he cause of death?
Vital Records,	sician: The law re certilicate has bee lirector, page 2 sho	omplet	Dementio	3									b. Were auto prior to co death? 1 \( \sum \section \text{Yes} \)	opsy findings available impletion of cause of
ita	ian: rtifica ctor, p	BeC	25. Was case referred to medica examiner?		/				26. Place	e of Deat	h (Check only			
	Physician: this certific ral director,	To	1 Yes 2 No	Hospital:	npatient 2	☐ ER/Outpatie	nt 3 DC	Othe	er: 4 □ Nu	ursing Ho	me 5 Resi	dence 6 🗆 0	Other (Specif	(y)
Division of	Attending Pl	Certification;	27. Manual of Death Natural 5 Pendir 2 Accident investi	gation	of Injury th, Day Year)	28b. Time o Injury	of A	8c. Injury Work	rat ⟨? Yes 2 □		28d. Describe			
Divi	ital or Attenders after death al Director:	Certifle	3 ☐ Surcide 6 ☐ Could 4 ☐ Homicide determ	nined 200. Flact	of Injury - At ing, etc. (Spec	home, farm, st	reet, factory	, office			28f. Location ( City or To		mber or Rura	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: Atter this certific completely filled in by the funeral director.	edicai	29a. Certifier 1 Certifyii (Check only one) 1 Medical	ng Physician: To the Examiner: On the b and man	e best of my ki asis of exami iner stated.	nowledge, dear nation and/or in	th occurred nvestigation	at the tim	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) and date and plac	manner as s e, and due to	stated. o the cause(s)
	To ti To ti	Σ	29b. Signature and title of certified				290	. License	number			29d. Date sig	ned (Month,	Day, Year)
)	and		144/2	Ser			D	00	~ 5	67	4	10/13	3/0	フ
/	MIN		30. Name and address of person	who complete caus	se of death (Ite	em 23a) (Type	Print)			٥.	^ .	1		,
	10.		JA Cock	ey, in	13	46 7	· Di-	171	m	44	, Jal	MAGN	7, N	1 9 3 1 E DA
	Sta Regist		31. Date filed (Month, Day, Year,	5 2007 32	egistrar's Sig	A for	barte	,						Day, Year)

Jack son Laws 215-12-6496

			For State Registrar	State of M	arylan	•	artmen rtificat				- '	giene	007	3483	3
2	Physicia		Decedent's Name (First, Middle, L. John Gor		ffmar	1			·		2. Date of Dea Month Octobe	Day	Year 2007	3. Time of Do	eath P M
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)			4b. City,	Town, or	Location of	of Death	000000		ounty of Death		
			613 W. Isabella	St.			S	alis	bury			Wi	comico		
	Funeral			Sex 7. Ag 1 <b>X</b> M 2□F		last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h y, Yea <i>r)</i>	9. Birth Cou	place (State or F intry)	-oreign
julya.	Director		214-30-7770 Usual Residence of Decedent	TAL W Z	72	Yrs.					4/30/	L935_	Mar	ryland	
	land ow		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City	Limits
	Mary 1 sh	to	Maryland Wicomi	.co	Sa	alisbu	CY							1 <b>K</b>  Yes 2	! □ No
	r 28e	Directo	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Cou	intry?	
	th with		613 W. Isabella	St.			2	1801				US	SA.		
	within 72 hours after death with the Maryland than ". I may call Examener noted by a halfied at Maylical Examener noted by a halfied at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Dece	dent of Hi	ispanic Ori n, Mexicar	igin? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Amer Black, White		
20	or it	by Fu	1 Never Married 2 Married	1 ▼Yes 2 ☐ If Yes, Give Year or Dates:	No ∧irFo		1 🗆 Yes		Specify:				necify:		
9500-c	hour tural		3 ☐ Widowed 4 🙀 Divorced  15. Decedent's 8		AILL	16a. Dece	dent's Heur	al Occup	ation			16b Kind	of Business/l	hite	
Ċ	in 72 n na	Completed	(Specify only highest g	rade completed)	- \	(Give	kind of wo	rk done o se retired	during mos	t of work	ing	TOD. KING	01 203110331	idustry	
7 7	d within jiene. r than "i	mo	Elementary/Secondary (0-12)	College (1-4or	5+)	Secui	city	Guar	đ			publ	ic cou	rt house	е
	e filed il Hygie other	9	17. Father's Name (First, Middle, Las	t)					18. Mothe		(First, Middle,	Maiden St	ımame)		
yland	uld be Mental irked o	To B	Walter Luffman						Myr	tis	Owens				
Mary	s 1 and 2 should be filed v f Health and Mental Hygie item 27 is marked other i other freumatic event, #		19a. Informant's Name/Relationship	(Type, Print)			-				al Route Numbe				
e, ≥	and and m 27		Sharon K. Sass/	daughter	201 0				Arm		New Ch				
	Pages 1 and the of the of the of the of the of the of the of the of the or o		20a. Method of Disposition 1   Burial 2 □ Cremation 3	□Removal from State	0	lace of Dispo	natory or c	ther plac	e) .	·	Date	20c. Loca	tion - City or 1	own, State	
IIIIIOL	t. Pa ntmen rtant: njury		Donation 5 Other (Spec	3//	MTC	omico Park					8/07		sbury,		
a Q	permit. Pages Department of the Important: if ite any injury or o		21 Signature of Funeral Service Lice				10110 501 S	way" now	Füner Hill	al H Rd.,	ome Pro Salisb	fessi urv,	onal A MD 218	ssociat: 04	ion
			23a. Partf. Enter the disease, or cor	nplications that cause	the death									Approximate	
	Physician		shock, or heart failure. List ont	one cause of each li	irje.		AKU	6						Onset and De	en ath
	/Medical		disease or condition resulting in death)	Due to (or as	a conseq	uence of):	750	9							
	Examiner		Sequentially list conditions	b									di-		
36	יו פ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence of):									
	be executed icien end burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	2 000000	uanaa af):									
Š	ate be executed hysicien end the burial-transit			Due to (or as	a consequ	derice or).									
09/89	phys phys s the	dical		d											
XOR	certif nding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23	d. Date of deli	very	
ă	death e etter	iciai	in the past 12 months?	1 ☐Live birth 4 ☐Pregnant a			]Ectopic p ] Other (sp						Month	Day Ye	ar
j.	by the	hys	9 Unknown	9□ Unknown											
ທົ	iaw requires that the death certificate as been signed by the ettending phys 2 should be detached for use as the	by P	Part II. Other significant conditions	contributing to death b	out not resi	ulting in the u	nderlying o	ause give	en in Part I					the cause of dea	
cords,	equir sen si ould										10	res 2 🗹	No 3∐Pro	bably 4 □Un	iknown
ပ္	law ras be	Completed									24a. Was autor	osy	prior to d	topsy findings av ompletion of cau	allable use of
<u> </u>	sician: The law certificate has t irector, page 2 s	Cou										2 No	death? 1 ☐ Yes	2 1 No	
VITAI	ysician: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:				Oth			(Check only o				
ō	Phys this ral dir	. To	1 Yes 2 No	1Inpatie		ER/Outpatier 28b. Time o		)n	4 [ ] [40		me 5 Resident			ufy)	
0	ding Phy h. After thi funeral d	tlon	1 Natural 5 Pending 2 Accident investigati	28a. Date of Inju (Month, Da	y Year)	Injury	м	28c. Injun Worl	k?` Yes 2 □		200. 000000				
DIVISION	Attending Physician: r death. sctor: After this certifici by the funeral director,	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of In	jury - At ho	ome, farm, sti	eet, factor	y, office					Number or Ru	ral Route Numbe	θ/,
5	el or s after ni Dire	Certification:	4 Homicide	building, et	tc. (Specify	y)					City or To	wn, State)			
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		(Check only 2 Medical Exa	hysician: To the best											
	thin 2 the mplet	Medical	one) 29b. Signature and title of certifier	and manner st	ated.		29	c. Licens	e number			29d. Date	signed (Monti	, Day, Year)	
	₹. <u>₹</u> .₹.8		No har				2.3	7 25	7044	1		101	17/07	, ,	
4	Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan		30. Name and address of person who	completed cause of	death (Item	n 23a) (Type	Print)	177				/	-		
	Char		Vel NATESAN	1415	5,	DIVISI	y√	5 he	cV	SAC	15BUR	1 h	1> 21	804	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 17	2007 32. Régistr	rar's Signa	iture	mel	D			15BUR				

07-08220 Kevin Clinton Murp		Please Type or Print in Black Indelible Ink. Er Str. State of Maryland / Department of Healt	n and Mental H	ygiene		2007 348
	Pa	or State Certificate of Death	1	2 Date of Dea	eg. <b>N</b> o. th	3. Time of Death
hysician		Decedent's Name (First, Middle,Last)		Month October 2	Day Y	<sup>'ear</sup> 0859 hrs
Me Examine		Kevin Clinton Murphy, Sr.  Facility Name (if not institution, give street and number)  4b. City, T	own, or Location of Death	1	4c. Coun	ty of Death
	48	4501 Romlon Street  Belts				George's
	_		er 1 Year   If Under 24Hrs			YY) 9. Birthplace (State or
Funeral Director		578-74-1331   1   X   Month	s Days Hours Mir	Dec.16	,1953	washington, DC
8	_	sual Residence of Decedent  a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
death with the Maryland or items 23a or 28a-f show any must be notified at once.		Maryland Prince George's Beltsville				1 Yes 2 X No
-f she	֓֞֞֞֜֞֡֓֓֓֓֓֓֓֡֡֓֡֓֓֡֓֡֡֡֓֡֓֡֡֡֡֓֡֡֡֡֡֡֓֡֡֡֡֡֓֡֡֡֡	De. Street and Number	Code			What Country?
he Marylam or 28a-f st	Ulrector	L1521 Big Creek Drive 20	705		Unite	d States
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		Lab Was Decedant Ever in U.S. 13 Was Deced	ent of Hispanic Drigin? ( S	Specify Yes or N		ace - American Indian, Black,
th wit		Married Armed Forces? If Yes, speci	ify Cuban, Mexican, Puert	to Rican, etc.)	٧ /	/hite, etc.
or it	호	1 1/4 Yes 2 No	2 X No specify:		Spec	#y: White
s after ral",		or Dates: 1972 1979	I Decupation (Give kind of	f work done	16b. Kind o	f Business/Industry
hour	딜누	Elementary/Secondary (0-12) College (1-4 or 5+)	orking life. DO NOT use re	etired)	C	tunction
36 in 72 han than	음	12   Carpenter				struction
with ber t	Completed by	7. Father's Name (First, Middle, Last)	18.Mother's Nar	ne (First, Middle	, Maiden Surn	ame)
filed filed at Hy	Be C	John Thomas Murphy, Sr.	Elizabe			
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than ke event, the Medica	하	9a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Addres	ss (Street and Number o	r Rural Route N	lumber, City or	Town, State, Zip Code)
shou and I	-	John T. Murphy -son   1302 McCo	y Court All		as /500	)Z
Baltimore, MD oemit, Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumati	-	20a. Method of Disposition (No. 20b. Place of Disposition (No.	·e)	Date		tion - City or Town, State
Ore		1 X Bunal 2 Cremation 3 Removal Holli State MD Veterans	Semetery  10	/26/200	7 Crown	nsville,Maryland
Lim Pag ment rant	1	4 Donation 5 Other Specify: 21. Signature of Funera e ice Livensee DONATO	d Address of Facility	dt Euro	rol Hor	no PA
Salt ermit Separ mpo	- 10	Defet 11 VI turning 4400 I	ı v. borgwar Powder Mill	Road Be	ltsvil	ne, PA le, Maryland2070
-	-+	23a. Part I. Emer the disease, or complications that caused the death. Do not enter the mod	e of dying, such as cardia	c or respiratory	arrest, shock,	or heart Approximate Intervention  Between Onset and
ysician Medical	- 1	failura. List only one cause on each line.				Death
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	I disease			
	- 1	b				
	je l	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated  C. Due to (or as a consequence of):				
sit d	Ι <u>α</u>	events resulting in death) Last				
ecuted and transit	ᇛ	d.				
be ex sician	影	y UNPENDED AMENDED, 27, perME, g873. 11/1	L/07 TT		23d. D	Pate of delivery
, P.O. Box 68760, rres that the death certificate be ex signed by the attending physician be detached for use as the burial.	Physician/Medic	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea	ath 3 Ectopic pre	egnancy	Mo	onth Day Year
68 certif	ian	past 12 months? Pregnant at time of death 5 Other (S			. Y/	
Sox leath e atte	yst	1 Yes 2 No 9 Unknown 9 Unknown		- 1		e contribute to the cause of death?
D. E		Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause given in Part I.			No 3 Probably 4 V Unknow
P.O.	ompleted by	Chronic alcohol abuse				
ds, een si	tec			T	Was an autopsy	24b. Were autopsy findings availa prior to completion of cause
OFC aw re has be 2 shc	βď				performed? (es 2 No	death? 1 ✓ Yes 2 No
Rec The l	Con		26.Place of Death (Ch	Line	C3 Z	
al faint iant certifi	Be	25. Was case referred to medical examiner? Hospital: 4 Inpatient 2 FR/Dutnatient 3	- Tau	lursing Home	Residence	ce 6 🗸 Other: Scene
Division of Vital Records, tal or Attending Physician: The law require an after death.  The Director After this certificate has been signed in by the funeral director, page 2 should be led in by the funeral director, page 2 should be	10 E	1 ✓ Yes 2 No	28c. Injury at Work?		cribe how injury	
of ing P After Unerz	ے ا	(Month, Day, Year)	1 Yes 2 No	0		
ion tendi eath. for:	Certification:	5 Pending			tion (Street and	d Number or Rural Route Number,
VIS or At fire d in by	E	3 Suicide 6 Could not be 28e. Place of Injury - At home, tarm, street, tac	ctory, onice building, etc.		wn, State)	
Dital ours a rilled I	er	4 Homicide determined (Specify)		17		manner or stated
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Functal Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the funeral director.		29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in the basis of examination and in the basis of examinati	at the time, date and place	e, and due to the rred at the time	date and plac	e, and due to the cause(s)
o the inhin in the imple	Medical	and manner stated.			794 D	ate signed (Month, Day, Year)
	≥	29b. Signature and title of certifier	29c. License number		1	·
1 grates	1	Mling Brassel MD	O.C.M.E.			ber 23, 2007
"		30. Name and address of person who completed cause of death (Item 23a)				1,100
		Melissa Brassell, MD Assistant Medical Examiner 111 Penr	n Street, Baltimore,	MD 21201		
	State	31 Date filed (Month May Year) 5 2007 32. Resistrar's Signature	M.			
Regi		SULUI ENGLES OF SULUIS			and a	
					DOME	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 9, 2007 **Physician** Mims Ruth 11:00p M /Medical 4b. City, Town, or Location of Death Silver Spring 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Fox Chase Rehabilitation Center Montgomery 9. Birthplace (State or Foreign Country) Mississippi 8. Date of Birth (Month, Day, Year) 03/30/1925 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🗓 F 82 578-36-5918 Yrs Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28e-f show treumatic event, the Medical Examiner must be nutified at D. C. 1X Yes 2 No Washington Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Items 23s or U. S. A. 20010 1008 Monroe Street, N. W. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. filed within 72 hours after 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify: þ 3 Nidowed 4 Divorced 'natural', Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Department Store Accountant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Impurient: If item 27 is marked of any Injury or other treumatic eve Susan Crowe Reuben Edward Mims 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Atlanta, Ga. 30349 3368 Walnut Ridge Duane H. Burke (Godson) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Deurial 2 Cremation 3 Removal from State Glenwood Cemetery 10/16/2007 Washington, D.C. ^ 4 □ Donation 5 □ Other (Specify) W. H. Bacon Funeral Home, Inc. 3447 14th Street, N.W. Washington, DC 20010 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Privisiciani 6 mos Congestive Heart Failure /Medical Due to (or as a consequence of) Examiner Atherosclerotic Cardiac Disease 1 yr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit and that initiated events resulting in death) Last the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Year Month ō in the past 12 months? 5 Other (specify) 1 Yes 2 XNo detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 ₩Unknown Hypertension Completed been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed: 1 Yes 21 No 2 No To the Hospitel or Attending Physicien: within 24 hours after death.
To the Funeral Director: After this certifica 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2K No 2 ER/Outpatient 3 DOA 2 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Chack o and manner stated 29d, Date signed (Month, Day, Year) 29b. Signature 29c. License number and title of certifie October 16, 2007 D28656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8609 Second Ave., Suite 404B Silver Spring, Md. 20910 Ravi Passi, M.D. Date filed (Month, Day, Year) 32. Registrar's Signature State DET 1 7 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 9:30 A M October 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Clintar trince Georges care Pineview ture If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 227 Hours 245 42 1 XM 2 ☐ F **Director** HAlifax Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla popertment of Health and Mental Hygiene. Important: If the 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Prince Georges 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? ineview Lane 15A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married ∠ Married Saltimore, Maryland 21215-0036 2×100 1 ☐ Yes Specify: Black Specify. Be Completed by 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Margaret 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6379 Maxwell Drive Bour boura bmes - Daughte Hd 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/12/07 Metropolitan Alexandria, Va. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenset 22. Name and Address of Facility Pope Funeral Home 20747 5538 Hariboro Pihe 11088 Forestville Hd 23a. P. nt1. Enter the disease, or complication of that caused the death. Dunot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one colors of near failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to ( resulting in death) /Medical consequence of) Examiner Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 ☐ Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Marrier of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 5 Pending investigation 1 V Natural Injury 1 ☐ Yes 2 No 2 Accident after death 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10,08,07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Laxmi Berwa 9106 Pinevi Pineview Lane Clinton Harvland 20135 Berwa 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Amend#26. PerPhys. PGC10-25-07 Gertificate of Death Reg. No 2. Date of Death Month **Physician** 110 lassnall QM 10 4 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1165 Bluebird Lane Crownsville Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 216-50-8880 Director 60 August 9,1947 Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits iral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Florida Monroe Directo Biq Pine Key 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 29662 West Cahill Drive 33043 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 ₩idowed 4 Divorced Year or Dates: "natural" er than "natur , the Medical I 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Defense Contractor Elementary/Secondary (0-12) College (1-4or 5+) Project Manager 7 is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental Arthur Marshall Elisabeth Supple ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra Marcia Wilhide /Daughter <u>3164 Rolling Road Edgewater MD 21037</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Oct. 16, permit. Pages Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Alexandria, VA. Metropolitan Crematory 2007 21. Signature of Puneral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 'RAS\_ breast ances /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an certificate has irector, page 2 s autopsy performed Yes 2 Z 2 🛮 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home of Hesidence 6 Nother (Specify) Name Hospital: 1 Yes 2 No ٩ 1 Inpatient -2 FF Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death i Director: d in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 10/15/07 DESZAZ 169 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste 300 900 Bestark RUS Dangolis. Jasin 31. Date filed (Month, Day, Year, 32. Registrar's Signatur

State

Registrar

OCT 1 7 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34836 Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** 722 AM Manor 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Hame Hyattsville Georg Thomas Moore Nursing Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F Hours 250-05-0180 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10d. Inside City Limits Yes 2 No Director HO Mariba 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20174 Burleigh by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Quban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 No Specify: Black 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Public. School 18. Mather's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be llie 09car Manor Jones ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) AWanda Manor-Daughter 13333 Burleigh St. Upper Harlboro Hd 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 19/07 Brentwood HD Ff Lincoln Cemeters 21. Signature of Funeral Service License 22. Name and Address of Facility Pope Funeral ilde 20747 5538 Pike Forestville Hd Mari boro or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest st only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, shock, or heart failure Immediate Cause (Final ndiounsculm **Physician** Artenosa MEAN disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) spital or Attending Physician: The law requires that the death certificate be executed ours after death.

Peral Director: After this certificate has been signed by the attending physician and filled in by the functured director, page 2 should be detached for use as the burlansit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 □Ectopic pregnancy 5 □ Other (specify) \_\_ in the past 12 months? Month 4□Pregnant at time of death 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performe rmed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 14 Zou7 completed cause of death (Item 23a) (Type, Print) Rensbury Rd Huattsville NB 20181 MD 4203QL 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34837 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Honor Constance Magill OCTOBER 0230 AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death 4c. County of Death Examiner HGNES SAL TIMORE If Under 1 Year Date of Birth (Month, Day, Year) Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Hours Days Country) New York 1 ☐ M 2 🔯 F 579-42-4511 74 Director 10-14-1933 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.

ant: If item Z is marked other than "natural", or items 23a or 28a-1 show any or other traumatic event, if he Medical Examiner must be notified at 1 ☐ Yes 2 No MD Director Prince George's Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20721 USA 15105 Mount Oak Road Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 2XNo Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White Completed by Specify. 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Patricia Ward Hugh C. Grogan မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1009 South Side Court, Nashville, TN 37204 Dana Ward Risk/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 'Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 10/19/2007 Brentwood, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature Funeral Service License 4739 Baltimore Avenue Gasch's Funeral Home, PA M01491 Hyattsville, MD 20781 233. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 9-3 days Immediate Cause (Final SEPSIS **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner NEUMONI Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine LEFT LEWER LUNG Saurmous ARCINOMA GI burial-tra Due to (or as a consequence of): MAGILL MONO(2\_\_\_\_\_ Division or Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1□Yes 2□No 9□Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown After this certificate has been signed funeral director, page 2 should be detected to the second of Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HRRHY' 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 20 No 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 22 No 1 Tes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death . Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital or 29a. Certifier 1 Cruifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar OCT 1 7 2007

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

18908

CATON AVE, BALTIMORE, MD

OCTOBER 15 2007

31.838 2007 Phu Do State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day October 22, 2007 0034 hrs 'ral Examiner Phu Do 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Say 7. Age (In yrs. last birthday) Funeral Country) Vietnam Months 574-36-5167 March 16, 1966 Director 41 YM 2 F Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d Inside City Limits Yes 2 X No 28a-f show notified at once. Columbia Maryland Howard Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code USA 8417 Oak Bush Terrace 21045 tems 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. permit. Pages I and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be a White, etc. Never Married 2 X Married Armed Forces Yes Asian Yes 2 No specify: If Yes, Give Year Specify: Widowed 1 Divorced \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) MD 21215-0036 12 Service Manager Restaurant 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be De Luona Muoi Do ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Oili Do/Wife 8417 Oak Bush Terrace, Columbia, MD 21045 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Oct. Date 28. crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Parklawn Memorial Park 2007 Rockville, Maryland Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22 Name and Address of Eachly lins Funeral Home Inc. 500 University Blvd. W. Silver Spring, MD 2090 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician Between Onset and failure. List only one cause on each line Medical Death Immediate Cause (Final disease Cardiac arrythmia ≟xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -XUNPENDED #23a,27,perME,g874, 12/11/07 TT Division of Vital Records, P.O. Box 68760, IE EEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 🗸 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy pnor to completion of cause of performed? death? No 1 🗸 Yes Yes 2 No To the Hospital or Attending Physician; 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: 1 Other 4 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 this Inpatient 1 Yes No 28a. Date of Injury (Month, Day, Year After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification X Natural Yes 2 Pending within 24 hours after death. To the Funeral Director: the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) **OCME** O.C.M.E. October 22, 2007 5 30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Morth Car. Year 5 istrar's Signatur State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

07-08211

ORIĞINAL

State Registrar 31. Date filed (Month, Day, Year)

OCT 1 7 2007

CECIL D. GEORGE M.D. 7500 HANOVER PARKWAY SUITE 101A GREENBELT MD

32. Registrar's Signature

			For State Registrar	State of	Marylan	d / Depa <i>Cer</i>	rtment of H tificate of L	ealth and N Death	Mental Hyg	iene <sub>eg. No.</sub> 200	7 34840
	Physici		1. Decedent's Name (First, Midd	Ellen	P;1	Ke			2. Date of Deat Month October	Day Y	3. Time of Death 3: 52 AM
	/Medio Examir		4a. Facility Name (If not institution		ber) Hospit	~1	4b. City, Town, or Hage	whenh	`	4c. County of	
ŀ	Funeral Director		5. Social Security Number 172–30–2446	6. Sex 7 1  M 2	7. Age (In yrs. I 74	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 3, 1	Year)	9. Birthplace (State or Foreign Country) Pennsylvania
	aryland show dat	ž	Usual Residence of Decedent  10a. State 10b. County  Marry 1 and 151 ac			, Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 🔯 No
	or 28a-f	Director	10e. Street and Number	shington	па	gersto	10f. Zip Code		10	0g. Citizen of Wh	
	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show ledical Examiner must be notified at	Funeral	18612 Wagaman  11. Marital Status	12. Was Deced	ces?	S. 13. V	21.7 Vas Decedent of His f Yes, specify Cubar		pecify Yes or No- o Rican, etc.)		American Indian, White, etc.
<b>2-003</b>	nours afte urai", or it Il Examin	by	1 □ Never Married 2 ☑ Mar 3 □ Widowed 4 □ Divorced	d If Yes, Give Year or Dat	9		☐ Yes 2 No	Specify:		Specify:	white
-2121	- 3 0	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed)  College (1	4or 5+)	(Give	lent's Usual Occupa kind of work done d OO NOT use retired) homema	uring most of wor )	king	16b. Kind of Busi	ness/Industry  n home
and 7	be filed ital Hyg d other event, i	Be	17. Father's Name (First, Middle Clarence Griff	e, Last)				18. Mother's Nam	ne (First, Middle, M	Maiden Surname)	
aryie	2 should be and Menta is marked aumatic ev	T	19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailin	g Address (Street a		Richner		tate, Zip Code)
re, M	1 and Health em 27 ther tr		George W. Pike		20b. P	lace of Dispos	12 Wagama sition (Name of natory or other place	1			and 21740 ity or Town, State
aitimor	permit. Pages Department of I Important: If It any injury or o		1 ⊠Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3	Specify)	itaite	dar Lav	wn Mem. P	ark 10/			own, Maryland
g Pa	Deperment of the population of		2 COTA	(1911)a	nne	4:	15 E.Wils	on Blvd.		town, Md	1. 21740
	Physician		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition	st only one cause on ea	ich line.				, ,	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	erch	uence of):	iratory cular	Acci	dent		1 week
	cuted d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (6	of as a consequ	dence of).					
58/60,	ficate be executed physician and sthe burial-transit	edical Exa	resulting in death) Last	Due to (o	or as a consequ	uence of):					
BOX DA	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	an/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome pf pregna		Ectopic pregnancy			23d. Date	
	at the dea by the att tached fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ 10 9 ☐ Unknown	4□Pregna 9□Unknov	ant at time of de wn	eath 5□	Other (specify)			Mont	h Day Year
ras, ı	requires that the een signed by th nould be detache	by	Part II. Other significant condit	tions contributing to dea		alting in the un	1 .		23e. Did tob		oute to the cause of death?  □ Probably 4 □Unknown
vital Records	25 0	Completed							24a. Was al autops perforr 1 Yes	y pri ned? de	ere autopsy findings available for to completion of cause of ath?  Yes 2 146
N I I I	sician: certifica irector, p	o Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Henrital	mationt 200	ER/Outpatien	Othe	r.	th (Check only on	e)	
on or	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the tuneral director, page		27. Manner of Death 1 ■ Natural 5 □ Pendi	28a. Date of		28b. Time of Injury	28c. Injury Work	4 LI Nursing H	ome 5 Reside		
UIVISION	il or Atter after dear i Director d in by the	Certification:	3 Suicide 6 Could	mined 266. Place C	of injury - At ho ig, etc. <i>(Specif</i> )	ome, farm, stre	eet, factory, office		28f. Location (St City or Town	reet and Number n, State)	r or Rural Route Number,
	e Hospita 124 hours e Funera letely fille	Medical C		ing Physician: To the ball Examiner: On the ball and manner	sis of examinat						
	To th withir To th comp	Me	29b. Signature and title of certific	er 20	· 1	0	29c. License	number 5 4 8 8	2		(Month, Day, Year)
1 4	11 12		30. Name and address of person	•			Print)	1.			18, 2007
	H-10 Sta		31. Date filed (Month, Day, Year		gistrar's Signa		HII Avo,	Mager	motes	MD ?	21742
	Registr	ar	HILL A	U ZUUI A	Occors -	5.80 000	Jan Barrelland				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Mary Helen Roy Oct. 19, 2007 10:25 A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frostburg Village Assisted Living Frostburg Allegany 8. Date of Birth 9. Birthplace (State (Month, Day, Year) 9. Sept. 26, 1922 Maryland 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex 5. Social Security Number **Funeral** Months Days Hours Min. 1 □ M 2 T F 213-22-3094 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No MD **Funeral Director** Allegany Frostburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or : 21532 USA 19300 Harvey Rd SW 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 → Widowed 4 □ Divorced 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lijury or other traumatic event once. Be Mildred (Laney) DeFries William DeVries 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Susan Sorge Daughter 233 St. Andrews Dr., Fort Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Silbaugh Crematory Oct. 24, 07 Uniontown, PA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hafer Funeral Service, PA 21. Signature of Funeral Service Licen-1302 National Hwy., LaVale, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARCINOMA **Physician** THREE YEARS LUNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner death certificate be executed Cause (Disease or inju-that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗷 No Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 XYes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a Was an has e 2 page After this certificate 1□ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 25€No 2 funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural 2 Accident Io tre....
within 24 hours after use...
To the Funeral Director: Afte 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

To the Hospital

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and titl

JAMES R. MOEN MO 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1063

29c. License number

WATIONAL IRGINAY

29d. Date signed (Month, Day, Year)

LAVACE MANYCAND

October 23, 2007

21302

Registrar DHMH 17 Rev 1/2001

State

205enbloom, Rosc

#1300 CHEUT CHASE, MANYUND 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MILASHIN

NELSON KALIL.

31. Date filed (Month, Day, Year)

16

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 12:24 am October 14 2007 Barbara Reichmann /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 11430 Strand Drive North Bethesda If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 Poland 6. Sex 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🗓 E May 15, 1915 Director 579-54-4677 92 Usual Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 1 X Yes 2 No Director North Bethesda Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 U.S.A. 11430 Strand Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🖾 No If Yes, Give 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify. Caucasian þ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Retail Liquor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Yitzchak Hersch Gomolinski Hendla Libeskind 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dr. Helen West - Daughter 1912 Biltmore Street, NW, Washington, DC 20009 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any Injury or oth 1 N Burial 2 □ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery 10/16/2007 Adelphi, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. Silver Spring, Maryland 20904 11800 New Hampshire Avenue, Approximate Interval Between Onset and Death Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 1 year Lymi homa disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine executed that initiated events resulting in death) Last burial-trans Due to (or as a consequence of): physician the death certificate be Physician/Medical the use as nding / IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant etten 3 Ectopic pregnancy Month Day Year Po in the past 12 months? 5 ☐ Other (specify) signed by the e d be detached for 1 ☐ Yes 2 ☒ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 k No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has page certificate 1∐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) Hospital: 1 TYes 2 X No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To il Director: After this id n by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? To the Hospital or Attending within 24 hours after death. 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours

To the Funeral C 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature D26406 October 15, 2007 dress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Jon Wiseman,

31. Date filed (Month, Day, Year)

M.D.,

1 6 2007

Saltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

egistrar's Signature

5410 Connecticut Avenue, NW, #117, Washington, DC 20015

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician 10:40 P M Alvina M. 13, Riley October 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 26, 1923 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 210 F 83 Director 084-18-0706 Queens, Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ir then "naturel", or items 23a or 28e-f ehow the Medical Examiner must be cottlied at 1 No 2 No MD Director Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be filed within 72 hours after death with 14044 Rockingham Road 20874 **IISA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Montag Marie Schumm 1 and 2 should treumatic 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Depertment of Health an important: if item 27 is eny injury or other tret page. Charles J. Riley Jr./Son 14044 Rockingham Road Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Calverton National 10/19/2007 Calverton, NY 4 ☐ Donation 5 ☐ Other (Specify) Cemetery

22 Name and Address of Facility

Robert E. Evans Funeral Home

Rowie. MD 2071 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 days **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, been signed by the attending physicien should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 XNo Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy his certificate his director, page performed' 2[XNo 1 Yes 2 X No 1 Tes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 XNo this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 XNatural 5 Pending within 24 hours after death.
To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and clare, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. 29b. Signatu and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0064502 October 14, 2007 30. Name and address of persor who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive Rockville, MD 20850 Brian Carpeler MD 32. Refistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygien Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 4:15 A 16 2007 October Virginia Repko Α /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Manor Healthcare Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 X F 216-20-1795 81 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County wode or Items 23s or 28s-f shov 1 ☐ Yes 2X No Director Rising Sun Maryland Cecil 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21911 211 New Bridge Road Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14 Bace - American Indian 11. Marital Status Pages 1 and 2 should be filed within 72 hours after de nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 1ry or other traumatic event, the Medical Examination. Black, White, etc. Specify: White 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Josephine Unknown Unknown Spishock 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 211 New Bridge Road, Rising Sun, Maryland 21911 Wanda Hill/daughter-in-law 20b. Place of Disposition (Name of 20a. Method of Disposition Carrison Forest Veterans Cemetery permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 10-23-2007 Owings Mills, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 21. Signature of all Service License 111 S. Queen St., Rising Sun, Maryland 21911 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) week **Physician** Urmany 1 ract /Medical Examiner Diabetec Jy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examine physician and s the burial-transit requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the attending IF FEMALE: esn 23d. Date of delivery 23c. ff yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 Pregnant at time of death 3 Ectopic pregnancy 2 Fetal death Year in the past 12 months? 1 ☐ Yes 2 ☐ No ö 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Domentia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the Certification: 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide determined 4 THomicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007 D0644373 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph K. Weidner Jr. MD Rising Sun, Maryland 21911 101 Colonial Way, 31. Date filed (Month, Day, Year) OCT 1 7 32. Registrar's Signature State 2007 Registrar

		ı	For State Registrar	State of Marylar	nd / Depa <i>Cer</i>	artment of H tificate of L	ealth and M D <i>eath</i>		en 2007	34846
	Physici	an	Decedent's Name (First, Middle, Last)	erfeld				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Fecility Name (If not institution, give str			4b City Town or	Location of Death	October	24, 2007 4c. County of Death	1647 <sup>M</sup>
7	Examin	er	824 Antietam Driv			Hagers			Washing	ton
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthp	place (State or Foreign ortry)
	Director		215-26-7985	4 2 <b>X</b> F 7	6 Yrs.	Months Bays		March 13	3,1931 Mar	yland
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or Lo	cation			1	0d. Inside City Limits
	Man,	tor	Maryland Washingto	on l	Hagerst	own				1 ☐ Yes 21☑ No
	ath with the Marylan i 23a or 28a-f ehow	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cour	ntry?
	sath w	erai	824 Antietam Drive	. Was Decedent Ever in U	16 112 1	21740		of Vec or No	USA 14. Race - Americ	ean Indian
21215-0036	tiled within 72 hours after death with the Maryland Hyglene. ther then "natural", or items 23a or 28s-f ehow ther then "natural", or items 23a or 28s-f ehow int, ite Mudical Exanting or item from the mulified at	by Funerai	11. Marital Status  1 Never Married 2 X Married  3 Widowed 4 Divorced	Was Decedent Ever in C Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Mas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2120 No	spanic Origin? (Spe n, Mexican, Puerto i Specify:	Rican, etc.)	Black, White,	etc.
5-0	72 hours 'natural', dical Ex	Completed	15. Decedent's Educa (Specify only highest grade		16a. Deced	lent's Usual Occupa kind of work done of	ation furing most of worki	ng 16	b. Kind of Business/In	dustry
121	within ane. then	idmo	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired,	)		D	
<b>d</b> 2	be filed withintal Hygiene. Id other then	Be Co	12 17. Father's Name (First, Middle, Last)		nom	emaker	18. Mother's Name	(First, Middle, Ma	Domestic  Aiden Surmame)	
/lan	2 should be to and Mental Hie marked ot reumatic ever	To B	Charles Knight				Elsie V	Valtrick		
Maryland	2 sho		19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street a	an <i>d</i> Number or Rura	l Route Number, C	City or Town, State, Zip	Code)
	es 1 and 2 should b of Heelth and Ments fitem 27 ie marked r other treumatic e		Donald Sommerfel  20a. Method of Disposition	20b.	Place of Dispo	sition (Name of	Drive, Ha		1, Md. 217 oc. Location - City or To	·
Baltimore,	permit. Pages 1 Department of H Important: if ite ony injury or ot		1 ☑ Burial 2 ☐ Cremation 3 ☐ Red 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	•	natory or other place	' 1			
alti	permit. F Departmo Importar eny Injur		21. Signature of Funeral Service Licensee		St Have	en Cemete  Name and Addres			agerstown, Funeral Cl	
Ö	Depared Important Importan		+ S. Mark Sin	Mp.			sylvania	Avenue, l	Hagerstown	•
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Cerl	eno	er the mode of dying		e dele		Approximate Interval Between Onset and Death
	Examiner		Conventially list and distance	Due to (or as a conse	quence ot):					1
11	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):			-		
har	icate be executed physicien and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
68760,	ysicier e buri	dical	<b>€</b> d.							
_			IF FEMALE:							
P.O. Box	Attending Physician: The law requires that the death certific death. clost. After this certificate has been signed by the ettending p by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	the distribution of the d	al death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
	res that the signed by be detacted.	by Pr	Part II. Other significant conditions contr	ibuting to death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to t	ne cause of death?
ord	w require been sig should b	ted	mulph	School.	215			1 ☐ Yes	2 □No 3 □ Prot	pably 4 Unknown
Division of Vital Records,	: The law cete has b page 2 st	Completed						24a. Was an autopsy performe	prior to co	psy findings available impletion of cause of 2 No
Zi:	ding Phyeician: Th n. After this certificete funeral director, pag	Be	25. Was case referred to medical examiner?	spital:	15D/0	Othe	26. Place of Death			
o	g Phy ter this neral di	n: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of	I 3 DOA	4   Nursing nor	ne 5 X Resident 28d. Describe how	ce 6 Other (Specification) occurred	y)
ion	ttending death. ctor: Aft y the fun	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(MONIN, Day Year)	Injury		Yes 2 □No			
i Š	or Atta	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str	eet, factory, office	1	28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	spital ours a serai C		29a. Certifier 1 Certifying Physic	cian: To the best of my kn	Owledge death	a coourred at the tim	ne, date and place	and due to the cau	see/s) and manner as s	tatod
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the t	Medical	(Check only 2 Medical Examine one)	r: On the basis of examination and manner stated.	ation and/or inv	estigation, in my op	pinion, death occurre	ed at the time, date	e and place, and due to	the cause(s)
	To the within To the comp	Σ	29b. Signature and title of certifier	1		29c. License	number	290	d. Date signed (Month,	Day, Year)
			Melene	1	1-1-> h	N Y	23623	10	When 2	6 2007
_	9		Frideralt KAS	pleted cause of death (Ite	m 23a) (Type,	rether	Cens	s Pal	Legerston	and un
27	Sta Registr		31. Date filed (Month, Day, Year) OCT \$ 0 20	32. Registrar's Sign	ature	and o	1		21	742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician РМ October 0 2007 2353 Fred Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci1 Union Hospital E1kton 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days 1**X** M 2□ F July 21, 1919 Virginia 88 Director 230-03-2826 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits 1 ☐ Yes 2 No Directo E1kton Maryland Cecil 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 United States 77 Mimosa Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: δ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Realtor Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William H. Smith Sarah Childress 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 77 Mimosa Lane, Elkton, Maryland 21921 Evelyn Smith/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date October 27. 1 XBurial 2 □Cremation 3 □Removal from State Union Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Union, Maryland 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Par L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner 1monic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying causes (Lissass of injury that initiated events resulting in death) Last Examine physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical signed by the attending p IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death Other significant equalitions contributing the eath but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2 autopsy performed' 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death uneral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and Mi person who completed cause of death (Item 23a) (Type, Print) 30. Name and address

DHMH 17 Rev 1/2001

State

Registrar

10344

W.

MD

OCT 3 0 2007

32: Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician Sulican Sade 00+ 12:53 PM Singh 2007 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland medical center Boltimore
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 28, 200 9. Birthplace (State or Foreign Country) Florida 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 X F 2 2005 215-73-1809 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Show 10a. State r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 3 20905 U.S.A. 705 Bonifant Road Funeral death th and Mental Hygiene. 7 is marked other than "natural", or items: traumatic event, the Medi: al Examlner mt 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔼 No altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify <u>≽</u> Specify: 3 Widowed 4 Divorced Other Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Diwan S. Singh Ellen Correia Melicio ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is other tra 705 Bonifant Road, Silver Spring, Maryland 20905 Ellen C. Singh - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 tment of 1 dant: If it 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. Union Cemetery 10/15/2007 4 Donation 5 DOther (Specify) Burtonsville, Maryland 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licensee 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediae Cause (Final **Physician** disease or condition resulting in death) chronic mand /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Du To (or as a consequence of): respirator 6 month Physician/Medical Examiner The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): Box 68760, physician attending p for use as use as IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death 9□Unknown Day Year 5 Other (specify) signed by the a P.0. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 1∏ Yes or Attending Physician; director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA this funeral 27 Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 5 Pending investigation 1 Natural 1 Tyes 2 🗆 No within 24 hours after death.

To the Funeral Director: / 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

16 2007 OCT

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Grea

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pawl a University of Maryland Medical Center NSE13, Pa **B**egistrar's Signature

29c. License number

D0066347

cosey

29d. Date signed (Month, Day, Year)

Oct 12

State	of Maryland /	Department of Health and	Mental Hygiene
. 700	7 10/15/07	Certificate of Death	7

		•	1 = For State Registrar/Amended # 31 F	er PG. CC 10/	15/07		tificate c			vicitai i iy	Reg. N	.200	7 34	849
ţ.	Physicia	an	1. Decedent's Name (First, Middle, Las	<i>t</i> )						2. Date of De Month	eath	ay Year	3. Time	
100	/Medic	al	James	Alfred	Su	mter			(D. 4)	October				00A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Tow		non or Deair	ı		c. County of Dea lontgome		
	Funeral	_	Social Security Number 6. S	ex 7. Age (	In yrs. last bi	irthday)	If Under 1 Ye	ear If U	nder 24 Hrs.	8. Date of Bir (Month, Da	rth	9. Bi	rthplace (State	or Foreign
.dis."	Director		250-13-0727	XM 2□F 49		Yrs.	Months Da	ys Ho	urs Min.	Aug 10	0 19	58 Sou	th Caro	lina
	land bw		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Tow	vn or Loc	ation						10d. Inside (	City Limits
	a-f sh	ctor	MD Prince Ge	orge's	Laur	e1							1 K Yes	s 2□No
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	Director	10e. Street and Number				10f. Zip Cod				-	itizen of What C	Country?	
	eath v	Funeral	7606 Woodbine	12. Was Decedent Eve	er in U.S.	13. W	2070		ic Origin? (S	pecify Yes or No		14. Race - Am	erican Indian,	
9	after d or iten niner		1 ☐ Never Married 2 🕅 Married	Armed Forces? 1 X Yes 2 ☐ No			Yes, specify ( ☐ Yes 2 🗖		exican, Puèrt ec <i>ity:</i>	pecify Yes or No o Rican, etc.)		Black, Wh	ite, etc. Black	
03	ours aural", c	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:					ecity:			ореспу.		
15-	be filed within 72 hours after death with the Marylan ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grades)	de completed)		a. Decede (Give k life. D	ent's Usual Oc ind of work do O NOT use re	cupation one during tired)	most of wor	king	16b.	Kind of Business	s/Industry	
212	d within giene.	omo	Elementary/Secondary (0-12)	College (1-4or 5+) 2 Years			am Man				F	rivate		
pu	12 should be filed w n and Mental Hygier is marked other ti raumatic event, th	Be	17. Father's Name (First, Middle, Last)							ne <i>(First, Middle</i> attleba		en Surname)		
<u> </u>	hould d Mer marke matic	T <sub>0</sub>	Washington Sum		19	h Mailinc	Address (Str		•			or Town, State,	Zin Code)	
Ma	nd 2 salth an 27 is r trau		Sandra L. Buchana									land 20		
ore,	es 1 a of Hea		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Place of	of Dispos	ition (Name of	f		Date		Location - City of		
Ē	Page ment ant: If ury o		4 □ Donation 5 □ Other (Specify		Ivy l		Cemete					rel, Ma		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Mente Important: If Item 27 Is marked any Injury or other traumatic er		21. Signature of Funeral Service Licen	see								Funeral MD 2078		
			23a. Part1. Enter the disease, o compshock, or heart failure. List only	lications that caused th	e death. Do								Approxima Interval B	ate
	Physician		Immediate Cause (Final disease or condition	a Metasta									Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as a c				10)						
		er	Sequentially list conditions,	b. Renal F										
	cuted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c		,								
, O	e exec ian an urial-tr		resulting in death) Last	Due to (or as a c	consequence	of):								
68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	•	d										
	leath certific attending p	n/Me	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome pf 1□Live birth 2			F-1'					23d. Date of d	elivery	
P.O. Box	e deat he atte ied for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir			Ectopic pregna Other (specify					Month	Day	Year
	w requires that the de been signed by the s should be detached	Phy	Part II. Other significant conditions of	ontributing to death but	not resulting	in the un	derlying cause	given in	Part I.	23e. Did	tobacco	use contribute	to the cause of	death?
rds,	quires n sign	d by	Diabetes							1 🗆	Yes	2 No 3 □ I	Probably 4	∭unknown
900	e law re has bee je 2 sho	Completed	Hypertension							24a. Was	s an	24b. Were	autopsy finding	s available
Œ E	The ate h	Com	End Stage Renal I	)isease						perf 1∐ Yes	ormed?	death?	completion of es 21X No	
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	0 T FR/0		2004	Othor:		ath (Check only				
0	g Phys er this eral dii	n: To	27. Manner of Death	28a. Date of Injury (Month, Day)	28b.	Time of Injury	OL DOA	Injury at Work?	Nursing H	28d. Describe		6 □Other (Sp jury occurred	pecify)	
Sior	Attending r death. ector: After by the fune	atio	1 ♠ Satural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		cary	injury		1 ☐ Yes	2 □ No					
Division or Vital Records,	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc.	- At home, f (Specify)	arm, stre	et, factory, off	ice		28f. Location ( City or To		and Number or i at <b>e</b> )	Rural Route Nu	mber,
	To the Hospital or Attending Phyithin 24 hours after death.  to the Funeral Director: After the Sompletely filled in by the funeral			ysician: To the best of										( )
	the Ho nin 24 the Fu	Medical	one)	niner: On the basis of e and manner state		ina/or inv				urred at the time				
	To the	~	29b. Signature and title dicattifier	a and	1.5		D64	ense nun 208	iber			Date signed (Mo.		
	(14)		30. Name and address of person who	completed cause of dea	th (Item 23a)	(Type, F	Print)					10 - 11		
-	SC.		Saadia Husain 330	7 Bel Pre	Road S			ng, l	1D_209	06				
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's			A.							
DH	MH 17 Rev 1/20		OCT 1 5 200/	dent Do	Geret	9	1							
			<b>45</b> ,			ORIO	GINAL							

ORIGINAL

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

\$

Completed

Be

ည

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

To the Hospital or Attending within 24 hours after death.

Division or Vital Records, P.O. Box 68760,

	4 Donation 5 Uniter (Specify)	Ft. Lincoln	Cemt. Oct. 1	10, 2007	Brentwoo	d, MD						
	21. Signature of Funeral Service License	e 22. Nam	e and Address of Facility Stew	art Funer	al Home.	Inc.						
	) Dungy,		Benning Road,									
	Immediate Cause (Final disease or condition	cations that caused the death. Do not enter the le cause on each line.	mode of dying, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death						
	resulting in death)	Due to (or as a consequence of):	NON									
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		2 PNEUM	MONIA	•							
lical Ex	resulting in death) Last	Due to (or as a consequence of):	4									
Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oic pregnancy r (specify)		23d. Date of de Month	livery Day Year						
占	Part II Other eignificant conditions con	irt II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
d by	AWUS	AUTS RENAL FALURE 1 Yes 200 3 Prob										
olete	ANASM	24a. Was an 24b. Were aut										
Completed by				autopsy performed? 1□ Yes 2	death?	completion of cause of						
Be	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)								
To	1 ☐ Yes 25 No	lospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 □ Nursing Hor	me 5 Residence	6 □Other (Spe	ecify)						
ation:	27. Manner of Death  1	28a. Date of Injury (Month, Day Year)  28b. Time of Injury  M	Work?	28d. Describe how inj	ury occurred							
Certific	3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, fabuilding, etc. (Specify)	ctory, office	28f. Location (Street a City or Town, Sta		ural Route Number,						
Medical Certification:	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examin	sician: To the best of my knowledge, death occu ner: On the basis of examination and/or investige and manner stated.	rred at the time, date and place, ation, in my opinion, death occurr	and due to the cause red at the time, date a	(s) and manner a nd place, and du	s stated. e to the cause(s)						
Ň	29b. Signature and title of certifier	um.	29c. License number 59284	29d. D	ate signed (Mon	th, Day, Year)						

DHMH 17 Rev 1/2001

State

Registrar

3

31. Date filed (Month, Day, Year)

OCT 1 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

HINGTON ADVENTIST

TANOMA PMRK MD-20912.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 34851 State of Maryland / Department of Health and Mental Hygien [ ] ] 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10 D 332 M 208 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Ba Baltimore OKINS 110 110 7 MOV If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/26/1947 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday If Under 1 Year 9. Birthplace (State or Foreign Days Months Hours 1□M 2\\ F 205-38-5000 60 Yrs. Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Franklin Shippensburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17257 USA 5944 Molly Pitcher Highway 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22☐No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔼 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tax Claim Specialist Franklin Co. Govt. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Esther Wright George Knouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5944 Molly Pitcher Highway, Shippensburg, Pa. 17257 Dennis Scott/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Parklawn Mem. Gardens 10/19/2007 Chambersburg, Pa. 17202 ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. 1414/14 J.L.Davis Funeral Home, Smithsburg, Md.21783 Lee YVIS Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) day 515 Sequentially list conditions, dany leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ( r s a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably

Physician /Medical Examiner

anding physician and use as the burial-transit

the attending

signed by the atter

page 2 should been

funeral director,

filled in by

completely

Medical

this certificate has

after death.

within 24 hours a To the Funerel D To the Hospitel

or Attending Physicien:

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

**Physician** 

/Medical

Examiner

10a. State

Director

Funerai

ð

Completed

Be

**Funeral** 

**Director** 

show r 28e-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neture!", or Items 23e or eny injury or other traumetic event, Item Netical Exal: it in it must be 1

Baltimore, Maryland 21215-0036

with the Maryland

Examiner Physician/Medical 2 Completed

Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 Ne

24a. Was an

1 Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No.

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death

5 Pending

investigation 6 Could not be determined

↑ Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day

28b. Time of Injury

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29a. Certifier (Check only one)

2 Accident

3 Suicide

29c. License number

RES-000

29d. Date signed (Month, Day, Year) 15

29b. Signature and title of certifier elle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Baltimore

05H-10

Gillian Newman 31. Date filed (Month, Day, Year) State OCT 1 7 2007 Registrar

North Wol 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 4:50 am Stone Richard Lee 2007 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ivista 5. Social Security Number If Under 1 Year | If Under 24 Hrs Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 1 □ M 2 □ F 78 216-22-2393 April 9,1929 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ∑Yes 2 No Director La Plata MD Charles 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 20646 USA 100 Edelen Station Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ¬Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher High School Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Robertson Stone Bessie Louise Gough 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Edelen Station, La Plata, MD Beverly Stone/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Rest Cemetery 10/19/2007 La Plata,MD 21. Signatur Funeral Service Licens 22. Name and Address of Facilit M01458 AREHART-ECHOLS FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respirtor UNKNOWN Due to (or as a consequence of): obstructive Pulmoney Disase un known STAVE CHIONIC END Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner renai UN KNOW .Wronic Due to (or as a consequence of) NAH UTO UN KNOWN IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide

The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical the ss been signed by the 2 should be detached þ Completed certificate hes page 2 or Attending Physician: funeral director, Be ဂ After this

death.

hours after death unerel Director:

hin 24 hours at Hospitel

within 7

filled in by

**Funeral** 

Director

"natural", or Items 23a or 28a-f show edicel Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after d
Department of Health and Mental Hygiene.
Important: If Item 27 Is merked other than "natural", or Iten
any Injury or other treumetic event, the Medical Examiner.

**Physician** 

/Medical

Examiner

and

21215-003

Maryland

Baltimore,

29a, Certifier (Check only one)

amuel

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier

29c. License number

29d. Date signed (Month, Day, Year) 15

ICCU Dept Fort washington, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11711

Registrar

Kleiman 31. Date filed (Month, Day, Year) OCT 17 2007

Livingston 32. Raistrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34853 Reg. No. 2 0 0 7 Certificate of Death . Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year 13, 2007 12:33PM OCTOBER Philip William Spalding 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death CHARLES PLATA MEDICAL CENTER If Under 24 Hrs Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **1** M 2□F Days 215-36-4120 March 22,1920 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9274 Crescent Lane 20646 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once."

**Physician** 

Examiner

**Funeral** 

Director

r 28a-f show notified at

ral", or Items 23a or Examiner must be r

death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a. State

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Ş	MD C	harles	La	Plata						1 □Yes 2X No
ĭĕ	10e. Street and Number				Zip Code			10g. C	itizen of What Co	ountry?
교	9274 Crescen	it Lane			20646	5			USA	
To Be Completed by Funeral Director	11. Marital Status  1 ★ Never Married 2 M  3 □ Widowed 4 □ Divorce	If Yes, Give			cedent of His pecify Cuban 2 XNo	panic Origin? (S , Mexican, Puer Specify:	pecify Yes or No Rican, etc.)	10-	14. Race - Ame Black, Whi	
edt		ent's Education	16a.	Decedent's Us	sual Occupat	tion		16b. Kind of Business/Industry		
nplet	(Specify only high	hest grade completed)		(Give kind of v life. DO NOT	work done du	uring most of wo	king	100.	And of Eddiness	muddity
<u></u>	10	1 1 1		Farm		40.14.11.11	(E) . haire		<u>Farmin</u>	g
Be	17. Father's Name (First, Middle Louis J. Spal	*				18. Mother's Nar Anna C.		-	en Surname)	
٩	19a. Informant's Name/Relatio		19h	Mailing Addre	es (Street a				or Town, State,	Zin Codo)
										Zip Code)
	Edward Sander 20a. Method of Disposition	s,Jr./Cousin	20b. Place of	Disposition (A	lame of	La Pla	ta,MD Date	2064	Location - City or	Town, State
		n 3 □Removal from State (Specify)		y, cřematorý o ospeh 's		ery 10/	17/07		nfret,Ma	
	21. Sign tun of Funeral Service	-2 / // \MILI	0945	AREH	and Address ART-EC	of Facility CHOLS FU	OME,	646		
_	23a. Part1. Enter the disease, shock, or heart failure. L	or complications that caused	e La P or respiratory	lata arrest,	, MD	Approximate				
	I IIIIII eulate Cause (Filia)			Interval Between Onset and Death						
	disease or condition resulting in death)	a. Due to (or as								
			,							
ner	Sequentially list conditions,	Due to (or as	a consequence	of):						
ä	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
EX	resulting in death) Last	Due to (or as	a consequence of	of):						
lica		d								
Mec Mec	IF FEMALE:	00- 15	-6							
Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic 5 □ Other					23d. Date of de Month	llivery Day Year
~	Part II. Other significant cond	itions contributing to death b	ut not resulting in	the underlying	g cause giver	n in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?
d b							1 [	] Yes	2  No 3  P	robably 4 Driknown
lete							24a. Wa	s an	24b. Were a	utopsy findings available
щc							per	opsy formed?	prior to death?	completion of cause of
ပို	25. Was case referred to medi	cal				26. Place of Dea	1□ Yes		lo 1 □ Yes	2 No
0	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	ent 2 □ ER/Ou	tpatient 3□I					6 ☐Other (Spe	ecify)
ation: T	27. Manner of Death  1. Natural 5 Pend 2 Accident inves	28a. Date of Inju	ry   28b. T	ime of njury M	28c. Injury Work?		28d. Describe			<i>May</i>
Medical Certification:	3 Suicide 6 Coul 4 Homicide dete	rmined   Zoe. Flace of III]	ury - At home, fai c. <i>(Specify)</i>	rm, street, fact	ory, office		28f. Location City or T	(Street a	and Number or R te)	ural Route Number,
edical (		yIng Physician: To the best al Examiner: On the basis o and manner st	f examination an							
ž	29b. Signature and title of certi		(·D	2	29c. License	number			ate signed (Mon	th, Day, Year)
	A liga	10 Chelle			n. 200	Tradi	2	10	111.108	

Registrar DHMH 17 Rev 1/2001

State

6620 CRAIN

HWY. SUITE 102 LA PLATA MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAIG, MD.

	1	For State Registrar  1. Decedent's Name (First, Middle, Last)	State of Maryland	Cei	tificate of L	Death		g. No.	3 4 8 5 4
Physicia /Medica	ın al	Juanita Ma	rie Tibbs				October	4, 2007 Yea	1:17 p <sup>M</sup>
Examine	er	4a. Facility Name (If not institution, give s Prince Georges C  5. Social Security Number 6. Sex	ommunity Hosp		4b. City, Town, or Chever	Ly If Under 24 Hrs.		4c. County of De	
Funeral Director			M 2√F 71		Months Days	Hours Min.	8. Date of Birth (Month, Day, July 17,	1936 Wa	ashington, D. (
show		10a. State 10b. County  D. C.		, Town or Lo					10d. Inside City Limits 1X Yes 2 □ No
- 88	Director	10e. Street and Number	Wa	shingt	10f, Zip Code		16	ng. Citizen of What	Country?
Den	급				20019	1		United S	-
2	by Fur	1052 -48th Place N 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi of Yes, specify Cubar 1 ☐ Yes 2☑ No		pecify Yes or No- p Rican, etc.)	14. Race - A	merican Indian, /hite, etc.
ie. Nedical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired,	ation during most of work )	king	16b. Kind of Busine	
ygien t, the	Sol	10		H	lousewife	40 North of North	- (Final Adiabeta A	Domestic	3
d oth	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, M		
Ment arke atic	2	Joseph E. Matthe					Lucille W		
alth and 27 is m er treum		19a. Informant's Name/Relationship (Type Warren Tibbs /Sp		19b. Maili	ng Address (Street a	ce N.E. V	Vashingto	n, D.C.	20019
ant: If Item		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, cre. $01$ :		Oct.1	15,2007	20c. Location - City Washingte	on, D.C.
Depertr Importa any inju		21. Signature of Funeral Service License	un 11080	2:	2. Name and Address Alexander 5538 Mar.	ss of Facility Pope Iboro PI	kė/Forėst	ville, M	d. 20747
hysician		23a. Parn. Efter the disease, or compliance, complianc	cations that caused the deather cause on each line.  Fatal Card			g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
/Medical xaminer		resulting in death)	Due to (or as a conseq Hypertensi	uence of):					
ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Colon Cand						
physicien and s the burial-transit	edical Exa	resulting in death) Last	Due to (or as a conseq	uence of):				·	
e attending of for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ™No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	□Ectopic pregnancy □ Other ( <i>specify</i> )	,		23d. Date of Month	delivery Day Year
been signed by	by	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	inderlying cause give	en in Part I.			te to the cause of death? ] Probably 4 ∰Unknowr
ate has	Completed						24a. Was a autops perform	ned? deat	e autopsy findings available r to completion of cause of th? Yes 2□ No
certificate	Be (	25. Was case referred to medical examiner?					ath (Check only on	re)	
r this ce ral dire	70	1 ☐ Yes 2 ŽNo		ER/Outpatie		4   Nulsing r		ence 6 Other (	Specify)
r death. ector: After this certific by the funeral director.	atlon:	27. Manner of Death 1 Abatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2∐No	28d. Describe ho	ow injury occurred	
in Dirt	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif		reet, factory, office		28f. Location (Si City or Town		or Rural Route Number,
24 hours a Funerel letely filled	Medical (	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, dea ation and/or i	th occurred at the tin nvestigation, in my o	ne, date and place opinion, death occu	e, and due to the curred at the time, d	ause(s) and manne late and place, and	er as stated. I due to the cause(s)
within 2 To the complet	Me	29b. Signature and tyle of contriber			29c. Licens	e number	2	9d. Date signed (A	Month, Day, Year)
5		· (VA)	9		De De	06592	_	10/0	70/14
BJ	-	ao. Name and address of person who co	ompleted cause of death (Iter	001	Hospita	Jr.	Chevar	ly Th.	D 20785
Sta Registr		31. Data filed (Month Days Year)	32. Registrar's Sign	ature	•			I	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0 200 0 bia 901 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name of not institution, give street and number. Examiner Medica ltimore 8. Date of Birth (Month, Day, July 7, 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Min. Months Days Hours 1**%** M 2∏ F 1960 Washington, DC 578-90-9734 Director 47 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1X Yes 2 □ No Laurel Maryland Prince George's Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13141 Larchdale Road, #13 United States 20707 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 County Employee Prince George's County 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eddie Tobias Mildred Young ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tawanna Tobias/Sister 11312 Kettering Lane, Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans 10/16/07 Cheltenham, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, Maryland 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Variceul Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Stuge Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-trar signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Nnknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2 4NO 1∐ Yes 2 14 No 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; completely filled in by the f 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined the Hospital 1 🔽 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2067 21212 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 N. Greene Street Bultimore MD 21201 Nayak MO 32. Registrar's Stonature Til 1/5 200 State

DHMH 17 Rev 1/200

Registrar

07-07957 Richard Turner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2007 34856 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 12, 2007 0011 hrs Turner Medical Examiner Richard c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Calvert Prince Frederick Calvert Memorial Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number Foreign Washington Country) DC **Funeral** Min Months Days Hours 08/20/1918 579-06-4919 89 Director 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ij 1 XYes 2 No Washington, DC DC s 23a or 28a-f show : e notified at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner. 10g. Citizen of What Country? Director 10f Zin Code 10e. Street and Number USA 3410 Carpenter Street, S.E. 20020 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Armed Forces? 1 Never Married 2 Married White If Yes, Give Year WWII 2 X No specify: Divorced 3 X Widowed 16b. Kind of Business/Industry 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed REA Express Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Supervisor 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carroll E11a Turner Samue1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 8340 Quince View La., Owings, MD 20736 Michael E. Turner - Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Suitland, MD crematory or other place) 1 XX Burial 2 Cremation 3 Removal from State 2007 October 16, Cedar Hill Cemetery Dopation 5 Other Specify. 22. Name and Address of Facility George P. Kalas Funeral Home, P.A 21. Significant of Funeral Service Ligenses MD 20745 6160 Oxon Hill Rd., Oxon Hill, Approximate Interval at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease or complications tailure. List only one cause on each line. Between Onset and Physician Death Necica a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Caus (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED g physician a 23d. Date of delivery Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy attending por use as the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 ✔ Unknown ð Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? this certificate has Yes 2 No Yes 2 V No 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical Be Other Hospital: examiner? Nursing Home 5 Residence 6 Other DOA 2 V ER/Outpatient 3 Inpatient No 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: Yes 2 1 V Natural 5 Pending Director: d in by the f 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be 3 Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier October 12, 2007 O.C.M.E.

State

Ana Rubio MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

**OCME** 

Registra

111 Penn Street, Baltimore, MD 21201

**ORIGINAL** 

			1 - For State Registrar	State of M	aryiano		tificate of	leaith and M Death	•	giene Reg. No.20	07	34857
ľ	Physici	00	1. Decedent's Name (First, Mid	1 1	1				2. Date of Dea		Year	3. Time of Death
9	/Medi		Helen El		ieme	yer			October	10,20	07	0304AM
Ĺ	Examir	ner	4a. Facility Name (If not institut	on, give street and number,	10	ondo	4b. City, Town, o	Location of Death		4c. County	of Death	_
-	Funeral	1	5. Social Security Number		ge (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birthpl	lace (State or Foreign
	Director		212-20-0063	1 □ M 2 🂢 F	80	Yrs.	Months Days	Hours Min.	(Month, Da) 4/13/1		Coun	MD
	land Dw		Usual Residence of Decedent  10a. State 10b. Coun	ty	10c. City,	Town or Loc	cation				10	0d. Inside City Limits
	Mary a-f she ified a	ţċ	MD K	ent	C	heste	rtown					1 □Yes 2 No
	ith the or 28	Direc	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Coun	try?
	s 23a	eral	213385 Pennsy			Lan		620		US		- 1 - 45
21215-0036	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notifiled at	t by Funeral Director	11. Marital Status  1 □ Never Married 2□XM. 3 □ Widowed 4 □ Divorce	I If Yes, Give	No		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2∏ No	tispanic Origin? (Spec an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	Black Specify	- America , White, e	
15-0	6	Completed	15. Deced (Specify only high	ent's Education nest grade completed)		16a. Deced	lent's Usual Occup kind of work done	oation during most of workin d)	g	16b. Kind of Bu	siness/Ind	lustry
212	should be filed within nd Mental Hygiene. marked other than " matic event, the Med	ошо	Elementary/Secondary (0-12	College (1-4or	5+)		keeper	4)		Accoun	tina	
b	be filed tal Hygind of other event, the	BeC	17. Father's Name (First, Middl	e, Last)		DOOK	Recepti	18. Mother's Name	(First, Middle,			
<u>ya</u>	ould be f Mental I arked of	ToE	Roland Kendal	1				Mildre	d Gill	_		
Maryland	12 should thand ment and Ment Is marked raumatic e		19a. Informant's Name/Relatio					and Number or Rural		-		*
	1 and 2 Health em 27 I		20a. Method of Disposition	meyer/musband	20b. Pla	ce of Dispos	sition (Name of	lvania Ave	ete	20c. Location -		
mor	Pages nent of nrt: If its iry or o			n 3 □Removal from State (Specify)	cei	metery, cren	natory or other plac	ion 10/11	/07	Stevensv	-	
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any Injury or othe		21. Signature of Funeral Service			22	. Name and Addre	ss of FacilityFe11	ows, He	elfenbei	n & 1	
	- S		23a. Part1. Enter the disease, shock, or heart failure. L	or complic tions that cause	d the death.						020_	Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to or as	enc	1/	Fail V	10				Interval Between Anset and Death
ŀ	Examiner		Sequentially list conditions,	b	3219	1541	Je h	lucar	Fail	vol	>	5 yrs
	ed sit	Examiner	ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseque	ence of):	1/011	111100	12 25	FRICIE	10	
in	tificate be executed ig physician and as the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):	VAC	Tuchi-	// 100	FICIE	7	
68760,	te be e	edical E		d								
	rtificat ng phy as th	Medi	IE EEMALE.									
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal c	death 3	Ectopic pregnancy Other (specify)	,		23d. Date Mor	e of delive ith	ery Day Year
Records, P.	w requires that the de been signed by the should be detached	þ	Part II. Other significant cond	tions contributing to death t	out not result	ting in the un	derlying cause giv	en in Part I.	23e. Did to			e cause of death?
CO	aw rec is beer 2 shou	Completed							24a. Was	an 🔑 24b. V	Vere autor	psy finding available
H R		Som	,		,				autor perfo 1∐ Yes	rmed?	eath?	npletion of cause of 2 No
Vital	Iclan: sertific ector,	Be	25. Was case referred to medic examiner?	Hospital:			Lou	26. Place of Death	(Check only o	ne)		
o	Physic ruthis crall direct	2	1 Yes 2 No 27. Man of Death	28a. Date of Inju		R/Outpatient		4   Nursing Horr		lence 6 DOthe		<i>'</i> )
on	th. ta Afte	tion	1 Natural 5 □ Pend		y Year)	Injury	28c. Injur Wor M 1 □	k? Yes 2 □ No	od. Describe i	low injury occurre	5 <b>u</b>	
Division	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificate if illed in by the funeral director,	Certification:	3 Suicide 6 ☐ Coul	mined   200, Flace Ul III	ury - At hom c. (Specify)	ne, farm, stre	eet, factory, office	2	8f. Location (S	Street and Number	er or Rurai	I Route Number,
	oital o urs aft eral Di											
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certify (Check only one) 2 Medic	ring Physician: To the best al Examiner: On the basis of end manner st	of examination	ledge, death on and/or inv	estigation, in my c	me, date and place, a ppinion, death occurre	nd due to the	cause(s) and ma date and place, a	nner as st and due to	ated. the cause(s)
	To T To 1	Σ	29b. Signature and title of certi	XCQ			29c. Licens	e number 3/205 4		29d. Date signed	(Month, I	Day, Year)
	5		29 Name and address of		7 19	22a) /Tur= 5	Do Oriet)			10 -	10-	OI
	Tm		Name and address of person	anahan Hi	2 121	0 50	peer RD'T	3HyBCh	estert	OHOUS	216	20
	Sta Registr	_	31. Date filed (Month, Day, Yea	1 0 2007 Regis	r's Signatu	As .	A-B	5				

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F			iene g. No. 200	7 34858
	Physicia /Medic		Decedent's Name (First, Middle Gladys	J •		Tharp		2. Date of Death Month October	Day Yea	M
300	Examin		4a. Facility Name (If not institutio  10 Evergreen  5. Social Security Number	Lane	ge (In yrs. last birthday	Ris	r Location of Death ing Sun If Under 24 Hrs.	h	4c. County of Do	eath
	Funeral Director		186-16-0201 Usual Residence of Decedent	1 M 2 XF	88 Yrs.	Months Days	Hours Min.	(Month, Day,	Year) 1919	Country) Maryland
:	the Marylan 28a-f show totified at	Director	10a. State 10b. County  Maryland  10e. Street and Number	Cecil	10c. City, Town or L	ocation  Rising Su  10f. Zip Code	n	10	ng. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 【X No
:	23a or	al Dii	214 Little No	ew York Road			911		USA	odana, .
2-00-6	permit. Faggs I and 2 should be filed within 7 z hours arer deam with the Maryland pergartment of Health and Mental Hygiene. Important: If then Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Mar  3 ☒ Widowed 4 ☐ Divorced	If Yes, Give	Ever in U.S. 13.	Was Decedent of HIf Yes, specify Cub. 1 ☐ Yes 2 ☒ No	lispanic Origin? (S an, Mexican, Puerl Specify:	specify Yes or No- to Rican, etc.)	14. Race - Al Black, W Specify:	merican Indian, hite, etc. White
0-6121	witnin 72 no ene. than "natur ne Medical I	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed)  College (1-4ors	5+) (Give	edent's Usual Occup e kind of work done DO NOT use retired Homemaker	during most of word)	rking	16b. Kind of Busine	,
ם כ	al Hygiene. I other than " vent, the Me	Be Co	17. Father's Name (First, Middle,			Homemaker		me (First, Middle, M		TOME
Z Z	z snould be and Mental is marked of raumatic eve	2	Solie Partee		19h Mail	ing Address (Street		Florence		a Zin Cada)
	Health and the Health		Jean Benham		- 1	Evergreen				
ore,	rages I a nent of He ant: if item ary or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from State		osition (Name of ematory or other plac	t		20c. Location - City	
Saitimor	artmen artmen ortant: injury e.		4 □ Donation 5 □ Other (5							, Maryland
Ď	Dep Imp any any		23a, Part1, Enter the disease, o	Chot die	d the death. Do not er	22. Name and Addre R. T. Foa 111 S. Qu nter the mode of dyir	een Stre	et, Risin	g Sun, MI	Approximate Interval Between
) <sup>r</sup>	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Pue to (or as	AFDIAL a consequence of):	INFARCTI	IN A	WIE		Onset and Death MINVTE
la.	Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. COKON  Due to (or as	a consequence of):	Try D	UEASÉ			YEARS
	the death certific the aftending points as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of Month	delivery Day Year
ecords, r.	Ine law requires that the tas been signed by the bage 2 should be detached.	þ	Part II. Other significant conditi	i <b>ons</b> contributing to death b	out not resulting in the	underlying cause giv	ven in Part I.	23e. Did tob		e to the cause of death? Probably 4 □Unknown
	icate has beer, page 2 sho	Completed						24a. Was ar autops perform 1∐ Yes 2	y prior	
Sion or vital	To the booking of Atlending Frigstrant: The law requires that the beath certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ation: To Be	Z LI Accident	Hospital: 1  Inpation  28a. Date of Injury  (Month, Date of Injury)	ury 28b. Time	of 28c. Injui	ner: 4 Nursing F	ath (Check only one Home 5 Reside 28d. Describe ho	nce 6X Other (S	Daughter's pecifyresidence
ואר האו	urs after de eral Directe	Certification:	3 ☐ Suicide 6 ☐ Could determ	nined 28e. Place of III building, e	iury - At home, farm, s tc. (Specify)			City or Town	, State)	Rural Route Number,
	n 24 ho	Medical	29a. Certifier  (Check only one)	ng Physician: To the best I Examiner: On the basis of and manner st	of examination and/or i	nvestigation, in my	me, date and place opinion, death occ	e, and due to the ca urred at the time, da	ause(s) and manner ate and place, and	as stated. due to the cause(s)
i	Mithii To th	Me	29b. Signature and title of certifie	1		29c. Licens		29	od. Date signed (Me	onth, Day, Year)
7	,		30. Name and address of person	who completed decise of	death (Item 23a) (Type	Print)	06525		10/15/0	14
	10		KOBERT	WORF, MI	213	E. MAN	ST. Re	sng sur	y po	21911
	Sta Registr		31. Date filed (Month, Day, Year, OCT 1 6 2	32. Registi	rar's Signature	le				

	* *	State of Maryland / Department of Health and Mental Hygiene	34859
-	For State Registrar	Certificate of Death Reg. No.	

Physician	ı
/Medical	L
Examiner	4
	ı

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23s or 28s-1 show early injury or other treumatic event, the Modical Examinant mast be notified as once. Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physicien and dompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Division of Vital Records, P.O. Box 68760,

	Registrar			Jerunca	te or t	Jealii			Reg. N	lo. "		
an	1. Decedent's Name (First, Middle, Last) E11a	Vines						2. Date of Di Month Octobe:	D		ear	3. Time of Death 2:10 P M
al er	4a. Facility Name (If not institution, give s	street and number)		4b. City	, Town, or	Location of				c. County of		2,10
	Washington Adventi	lst Hospita	a1	Tak	coma .	Park			N	lontgon	nery	
	Social Security Number     6. Sex	TAL OFFE	(In yrs. last birth	Months	or 1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Yea	r) 9.	Count	ace (State or Foreign try)
A1	579-46-5542	73	Y	rs.				July 1	L7,	1934 N	ort	h Carolina
	Usuat Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location							10	Od. Inside City Limits
ō	MD Prince Ge	orge!s	Adelphi									1 ☐ Yes 2X No
rect	10e. Street and Number	orge 3	пастри		ip Code				10g. 0	Citizen of Wha	it Count	try?
a Di	1820 Metzerott Roa	d #16			20783	3			US	Α		
ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Dece	edent of Hi	ispanic Orig	in? (Spe	ecify Yes or N Rican, etc.)	0-	14. Race Black,		
Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:				Specify:	7 00.10	, ilouri, citor,		Specify:		lack
ieted	15. Decedent's Educ (Specify only highest grade	cation e completed)	16a. [	Decedent's Usi Give kind of w life. DO NOT	ual Occupa rork done d	ation during most	of worki	ing	16b.	Kind of Busin	ess/Ind	lustry
ошо	Elementary/Secondary (0-12)	College (1-4or 5+) 2 yrs.	)	sonnel					Kan	sas De	pt.	Store
C	17. Father's Name (First, Middle, Last)					18. Mother	's Name	(First, Middle			•	
To B	Redman Dunn					E11	a Aı	ustin				
	19a. Informant's Name/Relationship (Ty)		- 4	Mailing Addres							te, Zip	Code)
	Lowana Richardson	/Daughter		20 Metz		Road			-	,	207	
	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	iemoval from State	20b. Place of to cometery.	, crematory or	other plac	. 1		-2007		Location - Cit hingto		
1	21. Signature of Funeral Service License	98 , 11	orenwoe.									me, Inc.
	* AP Mars	malls		4217	9th S	Street	, NI	W Wash	ning	ton, D	C :	20011
	23a. Parf. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Acute My Due to (or as a	7 <b>ocardi</b> a consequence of	1 Infa	rctic		ardiac c	or respiratory of	arrest,			Approximate Interval Between Onset and Death
n/Medical Examiner	Sauentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Atheroso Due to (or as a	clerosis	· S								
nysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetat death	3 ⊟Ectopic   5 ⊟ Other (s	pregnancy specify)					23d. Date of Month		ny Day Year
y PI	Part II. Other significant conditions con		not resulting in t	the underlying	cause give	en in Part I.		23e. Did	tobacc	use contribu	ite to th	e cause of death?
ed t	Diabetes Mellitus							10	Yes	2 <b>₹</b> No 3 (	Prob	ably 4 Unknown
mplet	Hypertension							24a. Wa auto peri	s an opsy formed?	prio	r to con th?	psy findings available inpletion of cause of
S	Hyperlipidemia  25. Was case referred to medical					OC Disease	of Dooth	1 ☐ Yes		No 1	Yes	2 No
0 8	examiner?	lospital:	2 🖾 ER/Outp	patient 3 🗆 🗅	Othe	ar	-17	me 5□Res		6 □Other	(Snecifi	/1
μü	27. Manner of Death	28a. Date of Injury (Month, Day)		me of	28c. Injury World			28d. Describe			Specify	·/
atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	rear/ Inj	ury M		Yes 2 N	lo					
ertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Ptace of Injury building, etc.	y - At home, farr (Specify)	n, street, facto	ry, office			28f. Location City or To			or Rura	l Route Number,
Medical Certification: To Be Completed by Physicia	29a. Certifier 1 ☑ Certifying Phys (Check only 2 ☐ Medical Examin one)	sician: To the best of ner: On the basis of e and manner state	xamination and	death occurre or investigation	d at the tim in, in my op	ne, date and pinion, deatl	l place, a	and due to the ed at the time	cause , date a	(s) and mann nd place, and	er as st I due to	ated. the cause(s)
Me	29b. Signature and title of cert fler	MO			9c. License					Date signed (1		
	30. Name and address of the number of Charles I. Frankl:				1112	0 New		npshire	Av	enue Si	uite	

State Registrar

31. Date filed (Month, Day Year) OCT 1 7 2007

32. Registrar's Signature

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	Registrar	ma /Fine ser	della 1 1						Death	10.5	Reg. N	0.	0 = :=
ian	Decedent's Na	, .	, ,							2. Date of I	D	ay Year	3. Time of Dea
ical	Mary D						T			Octobe			9:32 A.
ner	4a. Facility Name		-						Location of De	ath		c. County of Death	
	St. Vi		Care 6. Sex					mmitsb der 1 Year	ourg			Frederic	
	5. Social Security  022-40  Usual Residence	-0021		M 2 <b>⊠</b> F	7. Age (in y	94 Yr	Month	ns Days	Hours Mi		Day, Year	913 Maj	nplace (State or Fo untry) ine
_	10a. State	10b. Coun	nty		10c.	City, Town o	or Location						10d. Inside City Li
cto	MD	Fre	deric	ck		Emmits	sburg						1 <b>⊠</b> Yes 2 □
Director	10e. Street and N	umber					10f.	Zip Code			10g. C	itizen of What Co	untry?
	335 So	uth Set	ton A	venue			2	1727			U	J.S.A.	
Funeral	11. Marital Status 1 ☑ Never Ma		1	2. Was Dec Armed Fo	edent Ever in orces? 2 🕅 No	ı U.S.	13. Was De If Yes, s	cedent of His pecify Cubar	spanic Origin? 1, Mexican, Pu	(Specify Yes or I erto Rican, etc.)	No-	14. Race - Amer Black, White	
by	3 ☐ Widowed			If Yes, Gr Year or D	ve		1 🗆 Yes	2⊠ No	Specify:			Specify: Whi	te
ete	(Spe	15. Decede	ent's Educ	ation		16a. D	ecedent's U	sual Occupa	tion uring most of w	orkina	16b.	Kind of Business/l	Industry
Completed	Elementary/Sec		)	College (		i 'ii	fe. DO NOI Teac	use retired)	5, mg 1/1031 01 W	o.m.ng	1	igious C	ommunity f Charit
Be Co	17. Father's Name	First, Middle		701108			Teac		18. Mother's N	ame (First, Midd			I GHALIL
To	Henry V					-				nna Nath			
	19a. Informant's I					19b. N	lailing Addre	ess (Street a	nd Number or i	Rural Route Num	ber, City	or Town, State, Z	lip Code)
	Sister		Ia Ha	rant					ton Ave			burg, MD	
	20a. Method of Di	sposition 2 □Crematior	n 3 □Ba	amoval from	State S	D. Place of D	isposition (/\ cremato/ye	lame of r other place	,	Date	20c. l	Location - City or 1	Town, State
		5 Other		31110441110111	P	rovino	cial H	louse	10/	12/2007	En	mitsburg	J, MD
	21. Signature of F	uneral Servic	License			5	22. Name	and Address	s of Facility M	yers-Dur L. Emmit	bora	w Funera g, MD 21	l Home 727
1	23a. Part . Enter	the disease	or complic	eations that	Sused the de	eath Do not						3,	Approximate
	shock, or he	art failure. Lis	ist only one	e cause on e	each line.	<b>54</b> 11. <b>5</b> 51101	1	A -	, 30011 43 04101	ac of respiratory	arrost,		Interval Betwee
	Immediate Cause disease or condit resulting in death	ion	_ a.		lau	one	ed.	Ne	mer	Ma			2 reen
	resulting in death	,											
				yue to	(ras a cons	equence of	1	1/		0			1
.	Sequentially list of	onditions	<b></b> b.	Jue to	(ras a cons	sequence of	wol	He	more	hase			Cyn
ner	Sequentially list of if any, leading to cause. Enter Und	onditions, immediate	<b></b> b.	In	(or as a cons	sequence of sequence of)	hol	He	more	hage			Cyn
aminer	Sequentially list of any, leading to cause. Enter Unc Cause (Disease of that initiated even	IS	<b>∫</b> b.	In	(or as a cons	sequence of sequence of)	lud	He	more	hage			Cys
Examiner	Sequentially list of fany, leading to cause. Enter Unc Cause (Disease of that initiated even resulting in death)	IS	b. c.	Due to	(or as a cons			He	mod	hage			Cyr
	mat initiated even	IS	b. c. d.	Due to				He	mar	hage			Cys
edical	mat initiated even	IS	b. c. d.	Due to				Hé	engel	hage			Cys
edical	resulting in death)	is ) Last	b. c. d.	Due to	(or as a cons	sequence of)		He	mod	hage		23d. Date of deli	Cyr
clan/Medical	IF FEMALE: 23b. Was decede	nt pregnant 2 months?	b. c. d.	Due to	(or as a cons	sequence of): gnancy etal death	3 □Ectopic		mad	hage		23d. Date of deliment	
clan/Medical	resulting in death)  IF FEMALE: 23b. Was decede	nt pregnant 2 months?	b. c. d.	Due to	(or as a cons	sequence of): gnancy etal death			mad	hage			
Physician/Medical	IF FEMALE: 23b. Was decede in the past 1. 1 Yes 2. 9 Unknow	nt pregnant 2 months?		Due to  Due to  C. If yes, out    Live to    Pregr   9 Unknown	(or as a cons tcome of precipith 2 Frant at time o	gnancy etal death of death	3 □Ectopic 5 □ Other	(specify)	n in Parl I.	hage 23e, Die	tobacco	Month	Day Year
by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1.	nt pregnant 2 months? No incant condit	itions cont	Due to  Due to  C. If yes, out    Live to    Pregr   9 Unknown	(or as a cons tcome of precipith 2 Frant at time o	gnancy etal death of death	3 □Ectopic 5 □ Other	(specify)	n in Part I.			Month use contribute to	Day Year
by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1. 1 Yes 2. 9 Unknow	nt pregnant 2 months? No incant condit		Due to  Due to  C. If yes, out    Live to    Pregr   9 Unknown	(or as a cons tcome of precipith 2 Frant at time o	gnancy etal death of death	3 □Ectopic 5 □ Other	(specify)	n in Part I.	1	Yes :	Month use contribute to	
by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1. 1 Yes 2. 9 Unknow	nt pregnant 2 months? No incant condit	itions cont	Due to  Due to  C. If yes, out    Live to    Pregr   9 Unknown	(or as a cons tcome of precipith 2 Frant at time o	gnancy etal death of death	3 □Ectopic 5 □ Other	(specify)	n in Part I.	1 24a. Wa	Yes an	Month  use contribute to  2 XNo 3 Pro  24b. Were aul	the cause of death
by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1. 1 Yes 2. 9 Unknow	nt pregnant 2 months? No incant condit	itions cont	Due to  Due to  C. If yes, out    Live to    Pregr   9 Unknown	(or as a cons tcome of precipith 2 Frant at time o	gnancy etal death of death	3 □Ectopic 5 □ Other	(specify)	n in Part I.	1 24a. Wa	Yes an opsy formed?	Month  use contribute to 2 XNo 3 □ Pro 24b. Were aur prior to codeath?	the cause of death obably 4 Unkritopsy findings avail completion of cause
e Completed by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1. 1 Yes 2. 9 Unknow Part II. Other sign	nt pregnant 2 months? No n	itions cont	Due to  Due to  C. If yes, out    Live to    Pregr   9 Unknown	(or as a cons tcome of precipith 2 Frant at time o	gnancy etal death of death	3 □Ectopic 5 □ Other	g cause give		24a. Wa aut	Yes an opsy formed?	Month  use contribute to 2 XNo 3 □ Pro 24b. Were aur prior to codeath?	the cause of death obably 4 Unknown topsy findings avail completion of cause
Be Completed by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1: 1 Yes 2 9 Unknow	nt pregnant 2 months? No n	itions cont	Due to  Due to  C. If yes, out 1   Live to 4   Pregr 9   Unknown	(or as a cons tcome of precipinth 2 Fe nant at time o own	gnancy etal death of death	3   Ectopic 5   Other	g cause give	26. Place of D	24a. Wa aut per 1  Yes	Yes an opsy formed?	Month  use contribute to 2 XNo 3 □ Pro 24b. Were aur prior to codeath?	the cause of death obably 4 Unkritopsy findings avaiompletion of cause 2 No
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1: 1 Yes 2 9 Unknow Part II. Other sign  25. Was case refe examiner? 1 Yes 2 27. Manner of Dea	nt pregnant 2 months? No n ifficant condit	cal Ho	Due to  Due to  C. If yes, out    C. If yes, out	(or as a consistence of precipith 2 Frant at time of cown)  eath but not resulting the precipit for the prec	gnancy etal death of death resulting in th	3 Ectopic 5 Other   te underlying	g cause given	26. Place of D	24a. Wa aut per 1  Yes	Yes an opsy formed? 2 DN one) sidence	Month  o use contribute to  2 X to 3 □ Pro  24b. Were au prior to c death? 1 □ Yes  6 □Other (Spec	the cause of death obably 4 Unkritopsy findings avaiompletion of cause 2 No
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1: 1  Yes 2 9  Unknow Part II. Other sign  25. Was case refe examiner? 1 Yes 25	int pregnant 2 months? No n ifficant conditions ifficant condition	cal Ho	Due to  Due to  C. If yes, out    C. If yes, out	(or as a constitution of precipiting time of precipiting and at time of own leath but not reliable to the constitution of the	gnancy etal death of death resulting in th	3 Ectopic 5 Other   te underlying	g cause gives  Constitution of the constitutio	26. Place of D	24a. We aut per 1   Yes eath Check onh	Yes an opsy formed? 2 DN one) sidence	Month  o use contribute to  2 X to 3 □ Pro  24b. Were au prior to c death? 1 □ Yes  6 □Other (Spec	the cause of death obably 4 Unkritopsy findings availability of cause 2XNo
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow Part II. Other sign  25. Was case refe examiner? 1 Yes 2 27. Manner of Dea	nt pregnant 2 months? No n ifficant condit	cal Ho	Due to  Due to  C. If yes, out    Live to    Pregram   P	(or as a consistence of precipith 2 Frant at time of cown)  eath but not resulting the precipit for the prec	gnancy etal death of death resulting in th	3 Ectopic 5 Other the underlying tatient 3 1	g cause gives  Cause gives  Cause gives  Cause gives  Cause gives  Cause gives  Cause gives  Cause gives  Cause gives  Cause gives  Cause gives  Cause gives  Cause gives  Cause gives  Cause gives  Cause gives  Cause gives	26. Place of D	24a. We aut put put put put put put put put put p	S an opsy formed?  2 (2)  sidence s how inj	Month  use contribute to 2 No 3 pro 24b. Were aul prior to c death? 1 yes 6 Other (Spec	the cause of death obably 4 Unkritopsy findings avair completion of cause 2 No
Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1: 1	nt pregnant 2 months? No n ifficant condit	titions cont	Due to  Due to  Due to  Due to  C. If yes, out 1   Live to 4   Pregr 9   Unknown tributing to do  Dispital: 1   1   1   1   1   1    Zea. Date (Mon.)  Zea. Place building	tcome of precipith 2 Frant at time of own  eath but not repair to finiury th, Day Year)  of Injury - At ong, etc. (Spe	gnancy etal death of death resulting in th 28b. Tim Inju	3 Ectopic 5 Other ne underlying ne underlying ne of ry M , street, fact	g cause gives  g cause gives  DOA Other  28c. Injury Work: 1 Y	26. Place of D  7. St Nursing at  7. St □ No	24a. We aput per per per per per per per per per per	S an opsy formed? 2 (SN) sidence how inj	Month  y use contribute to 2 No 3 pro 24b. Were au prior to c death? 1 yes  6 Other (Spec ury occurred	the cause of death obably 4 □Unkr topsy findings avail completion of cause 2.2 No crify)
Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1. 1	nt pregnant 2 months? No n ifficant condit No hth 5 □ Pend inves 6 □ Coulc deter	titions cont	Due to  Due to  Due to  Control of the bound of the building to the building t	tcome of precipith 2 February 1 F	gnancy etal death of death resulting in th  BER/Outpa  28b. Tim Inju  t home, farm cify)	3 Ectopic 5 Other te underlying atient 3 te of ry M , street, fact	g cause gives  g cause gives  28c. Injury Work  1  Y  ory, office	26. Place of D  26. Place of D  26. Vursing at 7  es 2 No	24a. We per per per per per per per per per pe	Yes as an opsy formed? 2 (20) sidence a how inj	Month  use contribute to 2 No 3 pro 24b. Were aul prior to c death? 1 yes 6 Other (Spec	Day Year the cause of death babably 4 □Unkr topsy findings avaitompletion of cause 2.2 No 2.2 No cify)  ral Route Number,
edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1. 1	nt pregnant 2 months? No n ifficant condit  ifficant condit  No ath 5 Pend inves 6 Coulc deter	titions continued the state of	Due to  Due to  Due to  Control of the bound of the building to the building t	tcome of precipith 2 Feant at time of the common seath but not recommend to the common seath but not recomme	gnancy etal death of death resulting in th  BER/Outpa  28b. Tim Inju  t home, farm cify)	3 Ectopic 5 Other the underlying the underlying the of ry M , street, fact the occurre the investigation	g cause gives  g cause gives  28c. Injury Work' 1 Y  ory, office	26. Place of D  A Nursing at ? es 2 No  e, date and planion, death oc	24a. We per per per per per per per per per pe	yes an opsy formed? 2 (2) one) sidence a how inj	Month  o use contribute to  2 No 3 pro  24b. Were auring from to a death?  1 Yes  6 Other (Specury occurred  and Number or Rule)  s) and manner as and place, and due	the cause of death obably 4 Dunkritopsy findings avail completion of cause 2 No carry stated.
Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1. 1	nt pregnant 2 months? No n ifficant condit  ifficant condit  No ath 5 Pend inves 6 Coulc deter	titions continued the state of	Due to  Due to  Due to  Control of the bound of the building to the building t	tcome of precipith 2 February 1 F	gnancy etal death of death resulting in th  BER/Outpa  28b. Tim Inju  t home, farm cify)	3 Ectopic 5 Other the underlying the underlying the of ry M , street, fact the occurre the investigation	g cause gives  g cause gives  28c. Injury Work  1  Y  ory, office	26. Place of D  A Nursing at ? es 2 No  e, date and planion, death oc	24a. We per per per per per per per per per pe	yes an opsy formed? 2 (2) one) sidence a how inj	Month  o use contribute to  2 X No 3 □ Pro  24b. Were au prior to c death?  1 □ Yes  6 □ Other (Spec ury occurred  and Number or Ru te)	the cause of death obably 4 Unkritopsy findings availability 1 (2) No carry (2) No carry (3) Stated.  Stated. to the cause(s)
edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1. 1	nt pregnant 2 months? No n ifficant condit  ifficant condit  No ath 5 Pend inves 6 Coulc deter	titions continued the state of	Due to  Due to  Due to  Control of the bound of the building to the building t	tcome of precipith 2 February 1 F	gnancy etal death of death resulting in th  BER/Outpa  28b. Tim Inju  t home, farm cify)	3 Ectopic 5 Other the underlying the underlying the of ry M , street, fact the occurre the investigation	g cause gives  g cause gives  28c. Injury Work' 1 Y  ory, office	26. Place of D  A Nursing at ? es 2 No  e, date and planion, death oc	24a. We per per per per per per per per per pe	yes an opsy formed? 2 (2) one) sidence a how inj	Month  o use contribute to  2 No 3 pro  24b. Were auring from to a death?  1 Yes  6 Other (Specury occurred  and Number or Rule)  s) and manner as and place, and due	the cause of death obably 4 Unkritopsy findings availability 1 (2) No carry (2) No carry (3) Stated.  Stated. to the cause(s)
edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1. 1	nt pregnant 2 roonths? No n ifficant condit  ifficant condit  ifficant condit  Condition  1 Certify 2 Medica d title of/certifi	titions cont	Due to  Due to  Due to  Due to  Co. If yes, out    Co. If yes, out	tcome of precipith 2 February 1 F	gnancy etal death of death resulting in th  28b. Tim Inju t home, farm cify)	3 Ectopic 5 Other te underlying the underlying Matient 3 Interest of Ty Matter of Ty Matter of M	g cause gives  g cause gives  g cause gives  28c. Injury Work:  1	26. Place of D  AN Nursing at ? es 2 No  a, date and planion, death ocumber	24a. We per per per per per per per per per pe	yes as an opsy formed? 2 (20) one sidence a how injury. (Street a own, State a, date ar 29d. D	Month  o use contribute to  2 No 3 pro  24b. Were auring from to a death?  1 Yes  6 Other (Specury occurred  and Number or Rule)  s) and manner as and place, and due	the cause of death obably 4 Unkritopsy findings availability 1 (2) No carry (2) No carry (3) Stated.  Stated. to the cause(s)
edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1: 1	nt pregnant 2 roonths? No n ifficant condit  ifficant condit  ifficant condit  Condition  1 Certify 2 Medica d title of/certifi	ding stigation d not be mined ving Physial Exemine	Due to  Due to  Due to  Due to  Co. If yes, out    Co. If yes, out	tcome of precipith 2 February 1 F	gnancy etal death of death resulting in th  28b. Tim Inju t home, farm cify)	3 Ectopic 5 Other te underlying the underlying Matient 3 Interest of Ty Matter of Ty Matter of M	g cause gives  g cause gives  g cause gives  28c. Injury Work:  1	26. Place of D  AN Nursing at ? es 2 No  a, date and planion, death ocumber	24a. We per per per per per per per per per pe	yes as an opsy formed? 2 (20) one sidence a how injury. (Street a own, State a, date ar 29d. D	Month  o use contribute to  2 No 3 pro  24b. Were auring from to a death?  1 Yes  6 Other (Specury occurred  and Number or Rule)  s) and manner as and place, and due	the cause of death obably 4 Unkritopsy findings availability 1 (2) No carry (2) No carry (3) Stated.  Stated. to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Williams **Physician** 200+ Eugene /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 15611 Blackburn Street Accoheek Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Hours Months Days M 2□F 578-64-805 59 Yrs washington DC Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Hince George Coheek Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15611 2060 Was Decedent Ever in U.S. Armed Forces

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired). Elementary/Secondary (0-12) College (1-4or 5+) Truck Dr Yri vate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Illiams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1561 Blockburn Street ACCO Keek MD 20607 19a. Informant's Name/Relationship (Type. Print) Williams - Wife Zelonia 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cen Date 20c. Location - City or Town, State 20a. Method of Disposition 10/20/2007 permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Fort Haryland 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Robert Funeral Home 20747 5538 Harlboro tihe 23a. Part1. Enter the dise se shock, or heart failure. se or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line. Immediate Cause (Final **Physician** 2 months disease or condition resulting in death) /Medical Due to for as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 ☐ Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ★No 24a. Was an autopsy performed? Yes 20 No 1□ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death . Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1XNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident hours after death uneral Director: 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Funeral 29a. Certifie: 12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the within A 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064178 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

HARVINDER

OCT 1 7 200

31. Date filed (Month, Day, Year)

SINGH

WHC

32. Registrar's Signature

110

IRVING ST. WASHINGTON

State of Maryland / Department of Health and Mental Hygien 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Dav GEORGEANN Year **Physician** WINEHOLI Month 10:24A M 07 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Apr. 23, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 66 1 M 2 F Yrs. Director 218-38-2775 1941 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, It is Medicul Exarchise must be notified at 1 ☐ Yes 2X No Director Maryland Carroll Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 or Items 23e 886 Banner Ave. 21791 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after a nent of Health and Mental Hygiene. Int: If Item 27 Is marked other then "naturel", or Itel 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify 3 Divorced 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16h Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 own home homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jenny R. Wagner William Edgar Osborn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 is any injury or other tra Calvin B. Wineholt/ husband 886 Banner Ave. Union Bridge, MD 21791 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/10/2007 ` 4 ☐ Donation 5 ☐ Other (Specify) Pipe CreekCemetery nr. Linwood, MD 21. Signatur of Funeral Service Lice 22. Name and Address of Facility Hartzler Funeral Home affan Union Bridge, MD 21791 6 E. Broadway 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 140 CARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed SMOKER Box 68760. Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy certificate l 20 No Division of Vital 1 ☐ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 9 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funerel C 29a, Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) D58246 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 12 KAJAN TADIMALLA ESTMIN State 2007 Registrar

07-08070 Valentina Williams Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 34864

		1- For State Registrar	,	Certi	ificate of	Death		,,	Re	g. No.		
Physici	an/	1. Decedent's Name (First, Middle,	Last)						Date of Deat Month	h	rear	3. Time of Death
ledical Exami	ner	VALENTINA WILL							October 14	1, 2007		0853 hrs
		4a. Facility Name (if not institution,			4	b. City, Town, or I Chester	Location of	Death			ty of Death	
		4009 Bridgepointe Drive		/I	6 1 1 - 4 1 - 1 - 1 - 1		Liza i	0411	D-11(D)-		n Anne's	
Funeral Director		,		(In yrs. las	t birthday)	If Under 1 Year Months   Days		Min.			Foreign	hplace (State or n
Director		216-56-5463	1 M 2 X F	80	Yrs.				AUGUST	19, 192	.7 Co.	untry) RUSSIA
any		Usual Residence of Decedent  10a. State 10b. County		10c City T	own or Location	on.						10d. Inside City Limits
* *		,										1 Yes 2 X No
Aaryland 28a-f show 1 at once,	넑	MARYLAND QUEEN A  10e. Street and Number	ANNE'S	CHES	TER	10f. Zip Code			110	og. Citizen of	What Coun	
ie Mai or 28; fied a	Director											
ith th 23a notil		4009 BRIDGEPOIN  11. Marital Status	12. Was Decedent I	Ever in II S	13 Was	21619 Decedent of His	nanic Origi	in? / Sneci		UNITED		ES can Indian, Black,
72 hours after death with the Maryland "n"natural", or items 23a or 28a-f sho al Examiner must be notified at once.	Funeral	1 Never Married 2 X Mar	ried Armed Forces?			s, specify Cuban,					hite, etc.	our maidif, Sidok,
		3 Widowed 4 Divor	rced If Yes, Give Year	<b>X</b> No	1	Yes 2 X No	specify:			Specif	у: <b>WH</b> ]	ITE
urs a	d by	15. Decedent's Education (Specif	or Dates: fy only highest grade com	pleted) 1	16a. Decedent	s Usual Occupati	ion (Give k			16b. Kind of		
72 ho n "na al Ex	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5	+)	during mo	st of working life.	DO NOT (	use retired	)			
5-0036 led within 7 Hygiene. tother than	I d	12			HOMEM	AKER				OWN	HOME	
21215-003( uld be filed within Mental Hygiene. marked other tha	ပ	17. Father's Name (First, Middle, L	.ast)			1	18.Mother's	s Name (F	irst, Middle, M	laiden Surna	me)	
21215 ould be file Mental H marked (	Be	JOHANN DABROWO					HELI		UNKNO			
D 21 should ind Me 'is ma	은	19a. Informant's Name/Relationshi				Address (Street						- 0
MD and 2 sho salth and 2 sho sem 27 is		WILLIAM JOHN W  20a. Method of Disposition	ILLIAMS/HUSE			BRIDGEPO tion (Name of cen	INTE	DRIV	E, CHE	STER,	MARYL on - City or	AND 21619 Town, State
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		1 Burial 2 X Cremation	3 Removal from Sta		ematory or oth		netery,		BER 17	200. Localio	on - Oity or	Town, State
im. Page ment tant:	- 4	4 Donation 5 Other Spe		CHES	SAPEAKE	CREMAT	ION		007			LE, MARYLANI
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.		21. re of Funeral Service L	icensee	•	22. N	ame and Address LOWS , HE	of Facility	BEIN .	AND NE	WNAM F	UNERA	L HOME, P.A
		23a. Part I. Enter the disease, or o	The last course of the course	tho dooth F	1706	SHAMROC	K ROA	$\mathbf{D}$ $\mathbf{C}$	<u>HESTER</u>	. MARY	LAND	21619 Approximate Interval
Physician /Medical		failure. List only one cause o	n each line.				Suci as ca	ilulac oi Te	spiratory arre	sst, shock, or	rieart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Atherosclerotic C			ase						Death
			h	querice or).								
	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a conse	andre of).								
cecuted 1 and - transit		events resulting in death) Last	d.	querioe ory.								2
6 = -	/Medical	UNPENDED	AMENDED									
760, icate be ex physician the burial	Wed	IF FEMALE:	23c. If yes, outcom	e of pregna	ancy					23d. Date	of delivery	,
		23b. Was decedent pregnant in the past 12 months?	I Live birth		_	al death 3	Ectopic	pregnanc	у	Month	n [	Day Year
Box 687; death certificate attending	sici	1 Yes 2 No 9 V Unkn	4 Pregnant at t	ime of deat	th 5 Oth	er (Specify)						
D. B. t the de by the	Physiciar	Part II. Other significant condition	9OHKHOWH	but not res	ulting in the u	nderlying cause o	iven in Par	<del>1</del> 1	23e Did to	bacco use co	ntribute to	the cause of death?
ries that the signed by	þ		oonalbading to docum	50(1101100	and give and an	raonymy aadaa g		•				oably 4 🗸 Unknown
ords, w require is been sig	Completed								24a. Was	an 124	b. Were au	topsy findings available
COFC law re has be	βle								autop	sy		completion of cause of
tal Recc cian: The lav certificate ha	Ö								1 Yes	2 V No	1 Ye	es 2 No
Vital I ysician: his certifi director,	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatier		<del></del>		of Death (					
i of Vital Records, ing Physician: The law requir After this certificate has been si uneral director, page 2 should b	ဥ	1 Yes 2 No 27. Manner of Death	I I I I I I I I I I I I I I I I I I I		R/Outpatient	<u> </u>	Other <sub>4</sub>	Nursing H		Residence now injury occ		: Scene
_ = . `` ∉ I	ä	1 ✓ Natural 5 Pendir	28a. Date of Injur (Month, Day,Ye	y ear)	28b. Time of In	· · I _ :	ryat Work? ∕es 2 ☐		d. Describe r	iow irijury occ	curea	
Sior Attend death ector: by the	cati	relian	igation	At been	- form street	t, factory, office b			of Landian /	treat and No	mhor or Du	ral Route Number, City
Division tal or Attendii rs after death. al Director: /	ertification:	determ	not be	ury - Acrion	ne, iaim, siree	i, lactory, office b	ullully, etc	.   20	or Town, S		inder of ita	rai Noble Noribor, Oily
Lospid 4 hour nunerally fill	ပ	4 Homicide 29a. Certifying Physics	vsician: To the best of my	knowledge	death occurr	ed at the time da	ite and nlar	ce and du	e to the caus	e(s) and man	ner as state	
Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Ollook Olly)	iner:On the basis of exam	_								
To To	Me	29b. Signature and title of certifier	and manner stated.			29c. License	e number			29d. Date s	igned (Moi	nth, Day, Year)
*		his an	i no			O.C.N	M.E.			October	17, 2007	7
5		30. Name and address of person w	who completed cause of de	eath (Item 2	?3a)							
_		Ling Li, MD Assistan	t Medical Examiner	111 F	Penn Street	t, Baltimore, I	MD 2120	01				
		31. Date filed (Month, Day, Year)	32. Registrar	's Signature				_				
Regis	trar	OCT 1	7 2007 Blue	ر میں	15 /5/	Market 1						

			For State	State	of Maryla	nd / Depa	artment of rtificate c	f Health ar	nd Mental Hy	rgiene?	07	34865
			Registrar  1. Decedent's Name (First, Middle,			Cei	rificate c	or Death	2. Date of D	ney. No.		3. Time of Death
	Physicia		JUNE MARIE WICKL						OCTOBE	R 14	Year 2007	6:30 PM
	/Medic Examin		4a. Facility Name (If not institution,		imber)		4b. City, Town	n, or Location of			y of Death	
			200 TERRAPIN GRO	VE				NSVILLE			ANNE	
	Funeral		,	.Sex 1		s. last birthday) Yrs.	If Under 1 Ye Months Da		Min. (Month, D	irth ay, Year)	Count	
	Director		219-12-5822 Usual Residence of Decedent		83	113.			JUNE 2	3, 1924	MARYL	AND
	yland		10a. State 10b. County		10c. C	City, Town or Lo	cation				10	d. Inside City Limits
	Mar.	ctor	MARYLAND QUEEN	ANNE'S	S	CEVENSV	ILLE					1 ☐ Yes 2 No
	or 28	Directo	10e. Street and Number				10f. Zip Cod	е		10g. Citizen of		
	s 23a	ra	200 TERRAPIN GRO				2166		n? (Specify Yes or N	UNITED	STATE	
39	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show ery injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie  3 ▼Widowed 4 ☐ Divorced	Armed F	2 XNo		was Decement of the Yes, specify C	Cuban, Mexican,	Puerto Rican, etc.)	BI	ack, White, e	etc.
21215-0036	72 hou	Completed	15. Decedent's (Specify only highest	Education	n	16a. Dece	dent's Usual Oc	cupation one during most of	of working	16b. Kind of	Business/Ind	ustry
2	ithin 7	nple	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use re	tired)	a woming	OTTO TI		
	lled w lygier her th		12 17. Father's Name (First, Middle, La	net)		HOME	MAKER	18 Mother	s Name (First, Middl	OWN HO		
Maryland	d be find the cod of	Be c	JOSEPH RIEGER	131/					SZALKOWSK		<i></i>	
2	should nd Me mark	၉	19a. Informant's Name/Relationshi	(Type, Print)		19b. Maili	ng Address (Str		or Rural Route Num		n, State, Zip	Code)
	alth a 27 is		REBECCA WICKLUN	BILENK	I/DAUGHI	ER 2459	0 WILLS	TON ROAL	), DENTON,	MARYLA	ND 216	29
ore,	of He of He fitem r oth		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3	□ □ Bemoval from	1	Place of Dispo cemetery, cre	osition (Name or matory or other	place) O	CTOBER 16	20c. Location	- City or To	wn, State
altimore,	Peg ment tant: I jury o		4 □ Donation 5 □ Other (Spe	cify)	CI		KE CREMA		2007	STEVENS	VILLE,	, MARYLAND
Bai	permit Depar Impor eny In		21. Signature of Furneral Service U	Ste	The	F	ELLOWS, 06 SHAM	ROCK ROA	D, CHESTE	R, MARY		
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	mplications that nly one cause on	caused the de each line.	ath. Do not en	ter the mode of	dying, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Failu	uto	thouse				>	6 months
	/Medical Examiner		resulting an death)		o (or as a cons	equence of):	therise a					
		er	f any, leading to immediate cause. Enter Underlying	D	o (or as a consi	equence of):	anop a	my				
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	6								
Ó	e exection and and and and and and and and and an	Ex	resulting in death) Last	Due to	o (or as a conse	equence of):						
8760,	ficate be executed physician and is the burial-transit	dlcal	<b>'</b>	d								
9	ding p	/Mec	IF FEMALE:	23c If yes o	utcome of preg	inancy				224 [	ate of delive	o,
Box	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fe	etal death 3	☐Ectopic pregna ☐ Other (specif)					Day Year
o	the d by the ached	hysi	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9□ Unk			- '' '					
ď	s that	by P	Part II. Other significant condition	s contributing to	death but not r	esulting in the t	inderlying cause	given in Part I.	23e. Dio	I tobacco use co		e cause of death?
ğ	w requires to been signed should be		Dq	rusión			<del></del>		- 15	Yes 2□No	3 🗌 Prob	ably 4 Unknown
ecc	has be	Completed							24a. We aut	opsy	prior to cor	psy findings available inpletion of cause of
<u>~</u>	cate h	Con								formed? 2 1 10	death? 1 ☐ Yes	2□ No
Žį	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Other	of Death Check on			
ō	Phys r this ral dir	To	1 Yes 2 No 27. Manner of Death	1	Inpatient 2 e of Injury	ER/Outpatie		4 ☐ Nurs	sing Home 52 Re 28d. Describ	sidence 6 Co how injury occ		/)
on	Attending r death. ector: After by the fune	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		inth, Day Year)	Injury		Work? 1 ∐ Yes 2 ∐ N	0			1
Division of Vital Records,	Il or Attend after death Director: / d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	288. Plat	ce of Injury - At		reet, factory, off	lice		(Street and Nur own, State)	nber or Rura	I Route Number,
Ö	ital or irs afte ral Dir led in	Cert		56.	umg, clor (epe		Ale Take					
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	xaminer: On the	he best of my k basis of exami inner stated.	nowledge, dea ination and/or in	th occurred at the evestigation, in r	ne time, date and my opinion, death	place, and due to the n occurred at the time	e cause(s) and e, date and plac	manner as st e, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and me	annor otatoo.		29c. Lie	cense number		29d. Date sig	ned (Month,	Day, Year)
,	10	· ii	> 4Dvor	MD			_   1	00061	688	10/1	5 2	-F0e
	3	Î	30. Name and address of person w	_		tem 23a) (Type		ve ur	1ESTER	WD.	21619	1
	Sta	te	31. Date filed (Month, Day, Year)	6 2007							,	
		ar	OOT 1	2007	30	H	Rosselle I					

				-	-	
State of Maryland	Department of	Health and	Mental	Hygien	0 (	

		1_ For	State of Mai		artment of Healt		ental Hygie	2007	34866
		Registrar		Cei	rtificate of Dea	atn	Reg.	No.	107 (50)
Physi	ician	Decedent's Name (First, Middle	_				Date of Death     Month	Day Year	3. Time of Death
	dical	Hilda E. Wett:					October	11 2007	11:20 P M
Exan	niner	4a. Facility Name (If not institution			4b. City, Town, or Local	ation of Death		4c. County of Dea	ith
		Calvert Manor			Rising			Ceci	
Funera		5. Social Security Number	6. Sex 7. Age 1	(In yrs. last birthday) QQ Yrs.		Inder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Ye	ar) C	thplace (State or Foreign ountry)
Directo	or	217-16-1899 Usual Residence of Decedent		98 Yrs.			May 25,	1909   Pe	nnsylvania
and *		10a. State 10b. County	,	10c. City, Town or Lo	ecation				10d. Inside City Limits
Aaryl r sho	5	W 1 1		_ •	_				1 ☐ Yes 2 TNo
the N	Director	Maryland Ce	ecil	Kisi	ng Sun		100	Citizen of What C	ountry?
with	ä	1001 m 1					10g.		
eath	Funerai	1881 Telegrapl	n Road 12. Was Decedent Ev	erin II S 12	21911	ic Origin? (Spe	ofy Vec or No-	USA 14. Race - Am	erican Indian
ter d	Ş	1 Never Married 2 Mar	Armed Forces?		Was Decedent of Hispani If Yes, specify Cuban, Me	exican, Puerto I	Rican, etc.)	Black, Wh	
urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give **		1 ☐ Yes 2 ☑ No Spe	ecify:		Specify:	White
2 hot			nt's Education	16a. Dece	dent's Usual Occupation			. Kind of Business	
in 7	Completed	(Specify only highe	st grade completed)	life.	kind of work done during DO NOT use retired)	most of workii	ng		
i with	E	Elementary/Secondary (0-12)	College (1-4or 5+		ance Admini	strato	-	Insurance	e.
Hys H	O O	17. Father's Name (First, Middle,	Last)				(First, Middle, Maid		=
id be ked ked	To B	Luther M. Weti	tie		T.	izzie E	Kiehl		
Idn y idnied within 72 hours after death with the Maryland sand Mentle with the Maryland and Mentle with the Maryland is marked other than "natural", or trema 23a or 28a-f show aumstic event, the Medical Examinar has notified at	-	19a. Informant's Name/Relations		19b. Maili	ng Address (Street and N			ty or Town, State,	Zip Code)
and 2 and 2 ealth a n 27 is	11	John Smith/Gua	ardian	PO F	ox 945, Ris	ing Sur	n. MD 219	1.1	
		20a. Method of Disposition	irdian	20b. Place of Dispo	sition (Name of			Location - City o	r Town, State
permit. Pages 1 Department of H important: if ite		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		1	natory or other place)	10.16	2007		S 1 1
artme portan	اد	21. Salature of uneral Service		Brookvie	w Cemetery 2. Name and Address of F	Facility	-2007 <u>K1</u>	sing Sun	, Maryland
D S D D D D D D D D D D D D D D D D D D	Buc	0 K	1 ( )	/ R .	T. Foard F	'uneral	Home, P.	A.	3.0.4.4
		23a. Part1 Enter the disease, of	r complication that caused the		1 S. Queen			Sun, MD	Approximate
		shock, or heart failure. List	only one course on each fine						Interval Between Onset and Death
Physicia /Medica	_	disease or condition resulting in death)	Ja Sen		mentia	11 11			years
Examine	-		Due to (or as a	consequence of):					0
	<b>a</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to for as a	consequence of:					
ted	듵	cause. Enter Underlying Cause (Disease or injury	<						
xecu and	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):					-
e be ex	caiE								
icate phy:			0						
certii nding use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy				23d. Date of de	Alivery
eath etter	S S	in the past 12 months?	1 Live birth 2 4 Pregnant at ti		Ectopic pregnancy Other (specify)			Month	Day Year
S of the second	l X	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown		2 00.0. (0,000.1)				
that ed by deta	Ę	Part II. Other significant conditi	ons contributing to death but	not resulting in the u	nderlying cause given in F	Part I.	23e. Did tobac	co use contribute	to the cause of death?
sign d be			5100				1 ☐ Yes	2 No 3 F	Probably 4 □Unknown
Pe de la constant de	Completed						[ 04- WF	045 111	C Francisco Lebis
e lav	I d	•			·		24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
The The cate							1 □ Yes 2 🔾		s 25 No
ician ician ector	Be	25. Was case referred to medica examiner?	Hospital:		Other		(Check only one)		
Phys this	2	1 Yes 2 No	1 inpatient			-	ne 5 Residence		ecify)
After	o n	1 Natural 5 Pendir		Year) 28b. Time o	Work?		28d. Describe how i	njury occurred	
death death the	cat	2 Accident Investi 3 Suicide 6 Could	not be		M 1 Yes		296 Lagation (Ctrop	and Mumber or C	Pural Courte Mumbas
or A or A or A Direct	Certification:	4 ☐ Homicide determ		y - At home, farm, sti (Specify)	eet, factory, office	1	City or Town, S	t and Number or F tate)	Rural Route Number,
pitei ours a erel			an Observation To the Land						
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifyii (Check only one) 2 Medical	ng Physician: To the best of Examiner: On the basis of e	1	and the second second				
thin the	Me	29b. Signature and title of certifie	and manner state		29c. License num	nber	29d	Date signed /Mor	oth, Day, Year)
F ₹ 5		1 ,4-	La su men		7286	28	1	) p + 1	2 DENT
. 1		"Chalo	a page man		Dao		of.	. /	0,000
4		30. Name and addr s of person	Bridge St	ил (пет 23а) (Туре, . У 1-1-	trinti	2195	1/100	16 1	and mil
		31. Date filed (Month, Day, Year)	32. Registrar	's Signature			Caro	1 57.116	on the cause(s)  onth, Day, Year)  a, 2007  on per, M.D.,
	State		007 Rene	13 /	97. A				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day a Year Month **Physician** 11 lliams ames /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number, Examiner Hospice Wicomico ocestal the HOSDICE Salisb at If Under 1 Year If Under 24 Hrs. 8. Dale of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 **3** M 2 □ F 31 Aug 18, MD Director 218-85-9119 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show at 1▼ Yes 2 No other traumatic event, the Medical Examiner must be notified Director MD Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a USA 21804 Funeral 610 Dover St Pages 1 and 2 should be filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married ō altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Completed by 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) f Health and Mental Hygiene. Elementary/Secondary (0-12) Laborer Manufacturing 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James T. Williams, Sr. Lena Pugh ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 610 Dover St., Salisbury, MD 21804 James T. Williams, Sr./father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of P Important: If ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/20/2007 Salisbury, MD Green Acres Mem Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service License 22. Name and Address of Facility Lewis N. Watson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death arcinoma with Immediate Cause (Final **Physician** yeu disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ned by the ai ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 M No s certificate has b irector, page 2 s 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ၉ 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 X Natural 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

32 Registrar's Signature

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MID 21801

10-13-07

M. Name and Press of person who completed cause of death (Item 23a) (Type, Print)

of Manyland / Department of Health and Mental Hygier 0 0 7

			For State Registrar	State of Ma		artment of Health and M tificate of Death		Reg. No.	
	Physicia /Medic	- 380	Decedent's Name (First, Middle, Last, Gorman	) Wilhelm			2. Date of De Month	Day Year /2 200	3. Time of Death 7 2000 P M
	Examin	_	4a. Facility Name (If not institution, give PMINSULA REGIONAL		Censel	4b. City, Town, or Location of Death  59/1364/14		4c. County of Dea	•
	Funeral Director		5. Social Security Number 6. Se 215-01-0947	x 7. Ag	e (In yrs. last birthday) 39 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bin (Month, Da 1/21/1		thplace (State or Foreign ountry) aryland
	aryland ehow	2	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	vith the M	Direc	Maryland Wicomico 10e. Street and Number 1014 Monitor Cour		Salisbu	10f. Zip Code 21804		10g. Citizen of What C	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28e-f ehow any highty or other traumatic event, the Medical Exerting rolled to multified at anote.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:	No I	Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puerting Yes 2 № No Specify:	pecify Yes or No o Rican, etc.)		
21215-0036	nin 72 hou in "natura Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	(Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king	16b. Kind of Business	
	d be filed with ental Hygiene ked other tha c event, the	To Be Com	12 17. Father's Name (First, Middle, Last) Gorman Wilhelm	_	pipe	fitter  18. Mother's Nam  Mina S		Merchant M., Maiden Sumame)	larines
Maryland	nd 2 shoul Ith and Me 27 is mark	Ě	19a. Informant's Name/Relationship (7. Robert Wilhelm/se		19b. Mailir 1813	ng Address (Street and Number or Ru B Forestdale Dr.,	ral Route Numb Richmon	er, City or Town, State, Id, VA 2323	Zip Coda) D
Baltimore,	Pages 1 arent of Heanut: If item		20a. Method of Disposition  1  Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify		20b. Place of Disponsion Pland Moreland Park	matagrar ather piace)	Date L6/07	20c. Location - City o Baltimore	
Balti	permit. Departm Importa eny Inju		21. Signature of Funeral Service Licente	crea (FS)	24	None and Address of Facility I Followay Funeral I Follow Hill Rd.	Home Pro , Salisb	ofessional a oury, MD 21	Association 304
	Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aASPI	d the death. Do not enfone.  RAPON a consequence of):	er the mode of dying, such as cardiac		arrest,	Approximate Interval Between Onset and Death
$t_c$	Examiner	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a sunsequence of).				
3760,	certificate be executed uding physician and ise as the burial-transit	il Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):				
9	artificate bing physic	Medicai	IF FEMALE:	d.					
O. Box	ne death the atter hed for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. ff yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of d Month	elivery Day Year
0	w requires that the state of th	þ	Part II. Other significant conditions co	ontributing to death t	out not resulting in the u	inderlying cause given in Part I.		tobacco use contribute Yes 2 No 3	to the cause of death?  Probably 4 Unknown
Records,	e la has ye 2	Completed					24a. Was auto perf 1 Yes	ormed? death	autopsy findings available completion of cause o
Vital	/sician: s certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/Outpatie	Other	ath (Check only		pecify)
ion of	ing Witer	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ury 28b. Time o Injury	of 28c. Injury at Work?  M 1 \( \t \) Yes 2 \( \t \) No	28d. Describe	how injury occurred	
Division	al or Attandi s after death. I Director: A id in by the fu	Certification:	3 Suicide 6 Could not be determined	286. Place of In	itury - At home, farm, st tc. (Specify)	reet, factory, office		(Street and Number or own, State)	Rural Route Number,
	c the Hospital or Attandi ithin 24 hours after death, o the Funeral Director; A	edicai C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best niner: On the basis of and manner s	of examination and/or in	th occurred at the time, date and place exestigation, in my opinion, death occ	e, and due to the urred at the time	e cause(s) and manner s, date and place, and d	as stated. ue to the cause(s)
	To the To the comple	Me	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mo	nth, Day, Year)

Gorman Withelm 900 319361

31. Date filed (Month, Day, Year) State Registrar

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

SVETCANA GUTTERALZ 1415 SOUT

SOUTH DIVISION SHITE 13 SAISBURY MOZISOY

Natural 2 Accident

5 Pending investigation 6 Could not be determined

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only

Medical

State Registrar 3 Suicide

4 | Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peninsula Regional Med Ctr. 100E Carrollst Salisbury, Mb

Anthony

Frey 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature

			State of Maryland / I - State of Maryland / I - State Amend #1 Per Phy G873 11/05	Department of F		ntal Hygien Reg. N	_ 0 0 1	3 4 8 7 0
	Physicia		1. Decedent's Name (First, Middle, Last)  Ruth				2 007	16:52 PM
•	/Medic Examin	N	4a. Facility Name (If not institution, give street and number)  PANINSUM REGIONAL MEDICAL LANGE		or Location of Death		c. County of Death	,
ž	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 220−16−9352 1	Yrs. If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Yea /6/1926	r) Cour	place (State or Foreign htry) <b>yland</b>
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jical Examiner court be notities at	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow  Maryland Wicomico Salis  10e. Street and Number			100.6	Citizen of What Cour	10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	h with	al Dir	301 Glendale Drive	21804			USA	,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mentat Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be inclined at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, 2 No II Yes, Give Year or Dates:	13. Was Decedent of Hif Yes, specify Cub	dispanic Origin? (Specify an, Mexican, Puerto Ric Specify:	Yes or No- an, etc.)	14. Race - Ameni Black, White, Specify: wh	
Maryland 21215-0036	within 72 hou ane. than "natura ne Madical E	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working d)		Kind of Business/in	,
d 2	filed v Hygie other f	Be Co	17. Father's Name (First, Middle, Last)	office manag	18. Mother's Name (F			
ylan	outd be Menta arked attc ev	To B	Carl H. Smith Sr.		Gertrude			
Mar	id 2 sh Ith and 27 Is m traum			o. Mailing Address (Street BOL Glendale				Code)
Baltimore,	Pages 1 arent of Healuri, If Item 5		20a. Method of Disposition 20b. Place of	of Disposition (Name of the plant) CO Memorial	Date	20c.	Location - City or To	
Balti	permit. Departm Importal any inju		21. Signature of Funeral Service Ligangee	22. Name and Address Holloway 501 Snow	Funeral Hom	e Profes	sional As	sociation
1	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	not enter the mode of dyin	ng, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence					767100
8760,	icate be executed physicien and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence c	•				
6 - 935 0. Box 68	the death certily y the attending sched for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3 ⊟Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of deliv Month	ery Day Year
20-1	- v -	ed by Pł	Part IJ. Other significant conditions contributing to death but not resulting in	in the underlying cause gr	ven in Part I.	23e. Did tobacc	o use contribute to t 2 □ No 3 □ Pro	/
le 220	(0	Completed				24a. Was an autopsy performed 1 Yes 2	prior to co	opsy findings available impletion of cause of
1914 Vital	Physicien: this certific	Be	25. Was case referred to medical examiner?  1   Yes   2   No	ot ot	26. Place of Death (C		2 F0#/2	
3 2	ding Phys h. After this funeral di	n: To	27. Manner of Death 28a. Date of Injury 28b.	utpatient 3 DOA Time of lnjury Wo	4   Nulsing Home	5 Hesidence	6 □Other (Speci jury occurred	Ty)
242 Division	teat for: the	Certification:	1 Natural 5 Pending (Month, Day Year) 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fabrilloing, etc. (Specify)	M 1	Yes 2 No	Location (Street City or Town, St	and Number or Rur ate)	al Route Number,
, N -	a Hospitel or A 24 hours after of a Funerel Dirac letely filled in by	edical Co	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination are and manner stated.	e, death occurred at the tind/or investigation, in my	me, date and place, and opinion, death occurred	I due to the cause at the time, date a	o(s) and manner as s and place, and due i	stated. o the cause(s)
	To the within 2	Me	29b. Signature and title of certifier	29c. Licen:			Date signed (Month,	Day, Year)
<b>D</b>	DIA		1. Smelon, M.P., Ph.		689		7/11/07	
q	OM		30. Name and address of person who completed cause of death (Item 23a)  Tomasz SwierKosz 100 E. Car	(Type, Print)	lisbur M	1. 2180	21	
4	Sta Registr		30. Name and address of person who completed cause of death (Item 23a)  Tomasz SwierKosz 100 E. Car  31. Date filed (Month, Day, Year)  OCT 16 2007  32. registrar's Signature	Some?	J 1		-	

	)8287 Frederick <i>A</i>	cke	Please Type	or Print in BI of Maryland					_		
Ouri	T rederion 7		1- For State Registrar	or ivial ylariu	•	ate of Dea			Reg. No. 20	07	3487
Me	Physici dical Exam	an/	Decedent's Name (First, Middle,La		NI TO			2. Date of De Month	eath Day Year 24, 2007		ne of Death 46 hrs
- IVIC	alcai Exam	1101	CARL FREDERIC  4a. Facility Name (if not institution, g		M JR.	4b. City	, Town, or Location of		4c. County of		-101110
de			1912 S. Fountain Green			Bel			Harford		
	Funeral Director		5. Social Security Number 6.5 175-42-9461	Sex 7. Ag	e (In yrs. last birt 55		nder 1 Year   If Under hths   Days   Hours	<del></del>	13, 1952	9. Birthplace Foreign Country)	
			Usual Residence of Decedent								
	Ow any		10a. State 10b. County  Marvland Harford	1	10c. City, Town Bel Ai						nside City Limits Yes 2 No
	aryland 3a-f sh	Director	Maryland Harford  10e. Street and Number	L	per Ar		Zip Code		10g. Citizen of Wha		Jico - K
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		1912 South Four	ntain Greer	n Rd.	1	1015		USA		
	ath with tems 25	Funeral	11. Marital Status  1 Never Married 2 K Marrie	12. Was Decedent Armed Forces?			dent of Hispanic Origin cify Cuban, Mexican, I		No- 14. Race - White	American Ind	lian, Black,
	fter dez  ", or i er mu			d If Yes, Give Year	X No	1 Yes	2 No specify:		Specify:	White	2
	nours a natura	ed by	15. Decedent's Education (Specify	only highest grade con	pleted) 16a.	Decedent's Usu	al Occupation (Give ki		16b. Kind of Bus		
	36 in 72 h han "r dical E	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)				rate 1 ald		
	5-0036 iled within 7: Hygiene. I other than	Com	17. Father's Name (First, Middle, Las	<u>1+</u>	Гне	avy Equ	ipment Mec 18.Mother's	Name (First, Middle	Welding e, Maiden Surname)	1	
	1215 l be file ental H arked	Be	Carl Frederick A					e (nmn) S			
	MD 21 d 2 should lth and Me n 27 is ma	P	19a. Informant's Name/Relationship	•	4.0		ss (Street and Numb				
	e, M and 2 Health item 2		Margaret Katheri 20a. Method of Disposition		20b. Place	of Disposition (N	outh Fount	Date	20c. Location -		
	nor ages l ent of l nt: If		1 Burial 2 X Cremation 3 4 Donation 5 Other Specif		iie	ory or other plac	& Company	10-26-07	West Ch	ester.	PΔ
	Baltimore, permit. Pages I ar Department of Hee Important: If ite njury or other tr		21. Sign ture of Funeral Service L.C.		TOLLE		nd Address of Facility as Funeral			iobeor /	
			25a. Part I. Enter the disease, or com	uncations that caused	the death. Do no					ryland	21009_roximate Interval
	Physician /Medical		failure. List only one cause on	ach line. Asphyxia	the death. Do no	or enter the mod	e or dying, such as car	diac of respiratory e	great, arook, or nea	Bety	ween Onset and Death
	xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	equence of):						
		<u>,</u>	Sequentially list conditions, if any, leading to immediate	Exhaust fume in							
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	·							
	nted d ansit		events resulting in death) Last	Due to (or as a conse	equence of):						
	e executed cian and rial - transi	an/Medical			Bf per π	eo g872	10-31-07	vt			
	Box 68760, e death certificate be exthe attending physician ed for use as the burial	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor			th 3 Ectopic		23d. Date of Month		Year
	x 68 th certi tendin r use as	iciar	past 12 months?	4 Pregnant at	41 # J 41-	Fetal deal		pregnancy	World	Day	Teal
	. Bo	Physici	Part II. Other significant conditions	a OUKHOWII	but not recultin	g in the underlyi	ng cause given in Parl	23a Dio	tobacco use contri	hute to the car	use of death?
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burit	2	Fart II. Other Significant conditions	contributing to death	i but not resultin	g in the uncerlyi	ng cause given in Pan		res 2 ✓ No 3		
	Division of Vital Records, in or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed	V					24a. Wa			findings available tion of cause of
	leco he law ate has age 2 s	dmo						per		eath?	2 No
	tal Records cian: The law requi certificate has been ector, page 2 should	BeC	25. Was case referred to medical examiner?	D . 20			26.Place of Death (C	Check only one)			
	of Vit ing Physic After this	욘	1 ✓ Yes 2 No  27. Manner of Death	Hospital: 1 Inpatie	<del></del>	utpatient 3	DOA Other; 28c. Injury at Work?	Nursing Home 5	Residence 6 ve how injury occurre		e
	onding arth. r: After	Ejon:	1 Natural 5 Pending	FOUND: Day, Y	ear) FOL	IND:	1 Yes 2	Subject in	haled exhaust		
	ivision or Attencatter death Director:	ficat	2 Accident Investigat 3 Suicide 6 Could no	28e Place of In		7 hrs arm, street, facto	pry, office building, etc.	. 28f. Location	(Street and Number	r or Rural Rou	ute Number, City
	Division of Vital Rec To the Hospital or Attending Physician: The l within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Certification:	4 Homicide determin		ld			1912 south	, State) <b>Fount</b> Fountain road, B	al Air, MD	en ka.
	Fo the Hospital within 24 hours Fo the Funeral completely filled	Medical	29a. Certifier 1 Certifying Physicone) 2 Medical Examine	cian: To the best of m							e(s)
	To t To t	Med	29b. Signature and title of certifier	and manner stated.			9c. License number		29d. Date signe		

To The state of th

30. Name and address of person who complete cause o th (Item 23a)

Zabiullah Ali, M.D. Assistant Medical Examiner 1

State

31. Date filed (Month, Day, Year)

Registrar

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

October 25, 2007

State Registrar

Jctober 25, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DANIEUE DOBERMAN, MO

31. Date filed (Month, Day, Year) 0CT 3 1 2007

OCTOBER 24, 2007

6565 N CHAPLES ST, SWITE 209 BALTIMORE MD, 21204

Registrar

State

C. AJE

2007

1EMILOLU

31. Date filed (Month, Day, Year)

 $\Im$ 

SOUTH

2. Registrar's Signature

GREENE STREET BALTIMORE MD . JILOI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year **Physician** BOVO PM 9:05 barar October 2007 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Medica Baltimore Baltimore Center HOPKINS If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗰 78 Director MARCH 23,1929 228-34-0324 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD BALTIMORE **EDGEMERE** 10g, Citizen of What Country? 10e. Street and Number 10f Zin Code 2800 SPARROWS POINT ROAD 21219 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5 DOMESTIC HOME es 1 and 2 should be filed w of Health and Mental Hygiel f item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SAMUEL SINGLETON MARY L. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2800 SPARROWS POINT RD. EDWARD T. BOYD/HUSBAND BALTIMORE, MARYLAND 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 

Burial 2 □ Cremation 3 □ Removal from State 11-2-07 HOLLY HILL MEM. GRDN. MIDDLE RIVER, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signatur of Funeral Service Licenses 1701-31 LAURENS ST. BALTIMORE, MARYLAND 21217 23a. Part/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Se1515 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit be exec Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔊 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 ☐ Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 1, Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this funeral 27. Manner of Death 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? After Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fur 1 Tes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007 October 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Highf, Baltimore, MO Eastern 31. Date filed Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			Please 1	ype or Prin							_	ble.		
			For State	State of Ma	ryland / I	Departmer Certificat			lental H		100	77	3487	5
			State     Registrar  1. Decedent's Name (First, Middle, Last)			Certificat	e or	Death 	2. Date of D	Reg. N.	. 0 0	<i>J</i> 1	3. Time of Death	
	Physicia /Medic		FREDERICK (NMN		CK CK				Octob	Day		Year 2007	3:15 A	
	Examin		4a. Facility Name (If not institution, give	street and number)	- )	4b. City	Town, o	r Location of Death			-	of Death	-1	
			5. Social Security Number 6. Se	2Hh Care 6	(In vrs. last bit	rthday) If Unde	r 1 Year	If Under 24 Hrs.	8. Date of B	irth	_	9 Birthr	place (State or Fore	ian
	Funeral Director	1		M 2□F	78	Yrs. Months	Days	Hours Min.	Aug.	Day, Year) 4, 19:	29	Mary	ntry)	· ·
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location						1	0d. Inside City Limi	its
	Maryl t-f sho fied a	tor	Maryland Harford		Abing	don.							1 ☐ Yes 2 📆 🎙	No
	ith the	Funeral Director	10e. Street and Number		1202119		o Code			10g. Citi:	zen of V	What Cour	ntry?	
	eath w	eral	705 Long Bar Har	bor Road  12. Was Decedent E	ver in IIS	210		lispanic Origin? (Sp	acifu Vas or N	USA	14 Raci	e - Americ	can Indian,	
(0	after de or Item niner r		11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?  Yes 2 N  If Yes, Give		If Yes, spe	ecify Cuba	an, Mexican, Puerto	Rican, etc.)		Blac	k, White,		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentel Hygiene. If health and Mentel Hygiene. The marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	1000	1 ☐ Yes		Specify:			Specify	Wh	ite	
15 - -	in 72 h "natu ledica	Completed	15. Decedent's Edu (Specify only highest grad	e completed)		. Decedent's Usu (Give kind of we life. DO NOT u	ork done	during most of work	ing	16b. Kii	nd of Bu	usiness/In	dustry	
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+	·	udio Vis	sual	Repair		U.,	s. G	over	nment	
nd	be file	Be	17. Father's Name (First, Middle, Last)	ماد المحسمة				18. Mother's Name	·			•		
Maryland	2 should be and Mental Is marked o	ည	Charles (unk) B	rundick	191	o. Mailing Addres	s (Street	Caroline		,		geber State, Zir		
	1 and 2 s Health ar em 27 ls other trau		Shirley Brundick			-		Harbor Ro				•	,	
altimore,	0 0 <del>-</del> -		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	•	20b. Place o	of Disposition (Na ery, crematory or	me of other plac	ce)	Date				own, State	
Ē	permit. Pages Department of Important: If it any Injury or o once.		4 Donation 5 Dother (Specify)		Trini	-		Cem. 10-3			pa,	Mary	land	
Ba	permi Depa Impo any Ir		21. Signature of Funeral Service Licens			McCom	as Fi	uneral Ho sbury Roa	me, P.	A.	3.6-	7 -	0001C F	- 4
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused the cause on each line	the death. Do	not enter the mo	de of dyir	ng, such as cardiac	or respiratory	arrest,	#IVIC	aryıc	Approximate Interval Between	•
	Physician		Immediate Cause (Final disease or condition		imeni								Onset and Death Unknow	200
	/Medical Examiner		resulting in death)	Due to (or as a		of):		x'5 (1)	ممم	4			Hokows	
¥	p	Jer	Securifically list conditions if any, leading to immediate	Due to (or as a	conse ence		SILV (G	12.0	Su Sun	105			annow	7 8
	e executed an and urial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
60,	be exe	_	resulting in death) Last	Due to (or as a	consequence	of):								
687	death certificate be e attending physicia d for use as the bur	Physician/Medica		d										
Вох	th cert tending r use a	an/M	23b. was decedent pregnant	23c. If yes, outcome p 1 □Live birth		n 3⊟Ectopic⊯	regnanc	v		2		te of deliv	,	
		ysici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at t 9□Unknown		5 ☐ Other (s					IVIO	enth	Day Year	
<u> </u>	w requires that the de been signed by the s should be detached	y Ph	Part II. Other significant conditions co	ntributing to death bu	t not resulting i	n the underlying	cause giv	ven in Part I.	23e. Dio	l tobacco u	se cont	ribute to t	he cause of death?	
rds	equires en sigr	ed by							1	]Yes 2[	□No	3 ☐ Prof	oably 4 Unkno	wn
Records,	The law requires that the tee has been signed by thoage 2 should be detached.	Completed							24a. Wa	onsy	1 1		ppsy findings availal	
									per 1⊟ Yes	formed? 2 No		death? 1 🗌 Yes	2 □ No	
Vital	Attending Physician: r death. ector. After this certifice by the funeral director, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 <b>⊠</b> Inpatier	nt 2□EB/O	utpatient 3□ D	OA Oth	26. Place of Deat ner: 4 ☐ Nursing Ho				or /Sacri	6.1	
Division or	ding Phy h. After this funeral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day	y 28b.		28c. Inju	rv at	28d. Describ				(y)	
<u>S</u>	tendir eath. tor: Af the fu	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			М	1□	Yes 2□No						
	# te	Certification:	4 Homicide determined	28e. Place of inju- building, etc	ry - At nome, to . (Specify)	arm, street, tacto	ту, оптсе			(Street an own, State		er or Rur	al Route Number,	
_	ospita hours uneral ly fillec			sician: To the best o iner: On the basis of										
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f	Medical	one)	and manner stat					med at the tim					
	7 wit	<	29b. Signature and title of certifier	an			TO F	se number	Q	Zad. Dat	tak-	eu (ivionin,	Day, Year)	7
1	atl		30. Name and address of person wh	7	ath (Item 23a)		D.	04.0	1	0	, ,,,,,,	~ 0	1) 400	
1	0		Suresh Shande	lya, VA M	aryland	Health	Care	e System?	Herry	Min	7, 2	eg.	21902	ļ.
9	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	rs Signature	Anosti)	j.	•	•		-			
			001016	VI / 100 150	1 10	Egy Andrew								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1:60A M **Physician** 10.24.2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** baltimore W. Mosher Strect If Under 24 Hrs. Hours Min. Date of Birth (Month, Day, Year) 07.20-1925 9. Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months 1 M 2 F 220-24-4709 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Baltimore Director MLD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1216 Wosher Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", or Ite 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Plach Baltimóre, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Fordber's Balon 1+4 Beautician permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 is marked other it any Injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be cno 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) W. Mosher Street Baltimore, mo 21216 Daughk athi lones. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition Date 1 Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) 10.30.07 Baltimore, mD edar 22. Name and Address of Facility Vaughn C. Green & Lineaul Scrule 21. Signature of Funeral Service Licensee 5151 Baltimore National Pille Baltimore MO 21224 Vang m 23a. Part1. Ent of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of):  $BR_{\parallel}$  (5.14 T Records, P.O. Box 68760, Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by completely filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autops perform within 24 hours after death.

To the Funeral Director: After this certificate Yes 25. Was case referred to examiner? 26. Place of Death (Check only Other: 1 Inpatient 2 ER/Outpatient 3 DOA \$ Residence 6 □Other (Specify) 4 ☐ Nursing Home Medical Certification: To 1 Yes 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred r of Death Injury 1 V Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signer (Month, Day, Year) 29c. License numbe 29b. Signature and

State Registrar 30. Nar

31. Date filed

(Month, Day,

2007

DHMH 17 Rev 1/2001

ath (Item 23a) (Type, Print)

State Registrar Northway
31. Date filed (Month, Day, Year, DCT 3 1

HOS PITAL

Year) 2007

5401

32. Registrar's Signature

COURT ROAD

RANBALLSTOWN

OUD

21133

MP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie & UU 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Oct 26. Physician 11:58P₱ 2007 Harold Francis Biffle /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner 5310 Salima Street Prince George's Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1∏M 2□ F Yrs. Director 415 28 3892 Tenn Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiana. Important: if item 27 is marked other then "naturel", or itame 23a or 28e-1 ehow any injury or other traumatic event, the Mydical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Prince George's 1 Yes No Clinton Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5310 Salima Street 20735 <u>United States</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∏ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 XX Specify: À White 3 Widowed 4 Divorced 16b. Kind of Business/Industry
Investation Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 US AIrforce Office of Special 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Walker Jacob E. Biffle ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda Dumais (Daughter) 3730 13th Street, Chespeake Beach, MD 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov 5, \$2007 20a. Method of Disposition

1 Description | 2 Cremation | 3 Removal from State 20c. Location - City or Town, State Cheltenham, Maryland Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc6633 01d 21. Signature of Funeral Service Li mcc913 Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the disease shock, or heart failure. I Immediate Caurie (Final disease or condition resulting in death) idayons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death Due to (oras a consequence of): Heart Failure **Physician** /Medical Examiner Artoni DICHOUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-translt or Attending Physician: The law requires that the death certificate be executed the attending physicien and hed for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an After this certificate hes funeral director, page 2. autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home Specified 6 Other (Specify)

Injury at 28d. Describe how injury occurred Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural 5 Pending To the Hospital or Attendir within 24 hours aftar death.
To the Funeral Director: At completaly filled in by the fu 1 Yes 2 No death. 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/29/07 H66665 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

San Se D

Basil

200 Dasal 32. Megistrar's Signature

,00

JONA LESKUSKI 31. Date filed (Month, Day, Year)

			For State	State o	f Marylan		artment of hartificate of		d Mental Hy	/giene	9	
			Registrar  1. Decedent's Name (First, Mid	dle. Last)		Cei	tificate of	Death	2. Date of D	Reg. No	2007	31,879
	Physic		(, , , , , , , , , , , , , , , , , , ,		NTHIA	BARBER			Month OCT	25 Da	y Year 2007	10:24 A M
1	/Medi Examir		4a. Facility Name (If not institut			Dinobli	4b. City, Town, o	or Location of De			County of Death	
	6 <u>[1</u> ]		NATIONAL N	AVAL MEDIC				THESDA			MONTGOM	ſERŸ
	Funeral Director		5. Social Security Number N/A	6. Sex	7. Age (In yrs.	last birthday) Yrs.	Months Days		Hrs. 8. Date of Bi (Month, D	ay, Year)	Cou	place (State or Foreign ntry) nland
	and w		Usual Residence of Decedent 10a. State 10b. Coun	tv	10c Cit	y, Town or Lo	cation					10d. Inside City Limits
	Maryla f sho ied at	jo.	Maryland Princ	,		Brandy						1 □Yes 2□No
	r 28a-	Director	10e. Street and Number	e dedige		Drandy	10f. Zip Code			10g. Cit	izen of What Cou	
	death with the Maryland ms 23a or 28a-f show r must be notified at		8609 Lonic	era Court			206	13		Un	ited Sta	ates
	r dea	Funeral	11. Marital Status	Armed Ec	edent Ever in U.		Vas Decedent of F f Yes, specify Cub	Hispanic Origin?	(Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Ameri Black, White,	
215-0036	o 72 hours after death with the Marylan "natural", or items 23a or 28a-f show idical Examiner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorce	I It Yes Gi	21 No ve X No ates:		I□Yes 2√√No	Specify:	,		Specify: Bla	
5-0	72 ho 'natur dical	Completed	15. Decede	ent's Education lest grade completed)		16a. Deced	lent's Usual Occup	oation during most of	workina	16b. K	ind of Business/Ir	
121	within ene.	mpl	Elementary/Seçondary (0-12)		1-4or 5+)	life. L	kind of work done	d)				
d 21	filed v Hygie ther t	ပ္သ	N/A 17. Father's Name (First, Middle	 e. Last)		<u> </u>	N/A	18 Mother's N	Name (First, Middle	- Maiden	N/A Surname)	
Maryland	lid be lental <b>ked o</b> ic eve	To Be		Dean Barb	er				acey Hor			
ary	and M and M s mar	-	19a. Informant's Name/Relation			19b. Mailin	g Address (Street		Rural Route Numi		or Town, State, Zi	p Code)
	and 2 ealth a n 27 i		Gregory Bar	ber (Fathe					, Brandyw	ine,	MD 2061	3
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical once.		20a. Method of Disposition 1 X Xurial 2 □ Cremation	3 □Removal from			sition (Name of natory or other pla			20c. Lo	ocation - City or T	own, State
Iţi	It. Partmen rtmen rtant: njury		4 Donation 5 Dother	Specify)	M	aryland	l Vetera	ns Cemet	tery	Che	ltenham,	MD
Ba	permit. F Departm Importar any Injur		21. Signature of Funual Servi	The same	M014	64 A	. Name and Addre Lexandria	a Ferry	ee Funera Road, Cl	l Ho	me, Inc n, MD 2	6633 Old 0735
			23a Part1. Enter the disease, shock, or heart failure. Li	or complications that of st only one cause on e	aused the deat	h. Do not ente	er the mode of dyi	ng, such as card	diac or respiratory	arrest,		Approximate Interval Between
	Physician	İ	Immediate Cause (Final disease or condition	_ a.	EXTREM:	E PREMA	ATURITY					Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):						
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to	or as a conseq	uence of):						-
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b>		,					ŀ	
oʻ	e exectan an an arrial-tr	Еха	resulting in death) Last	Due to	(or as a conseq	uence of):						
68760,	icate be executed physician and the burial-transit	dical		d		-						
_	certific ding p	/Mec	IF FEMALE:	220 If you gut	name of preson	1001						
Box	eath c aften	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐Live b	come pf pregna birth 2☐Feta nant at time of d	Ideath 3□	Ectopic pregnanc Other (specify)	у			23d. Date of deliv Month	ery Day Year
P.O.	the d by the ached	hysi	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□Unkne		00						
	requires that the death certific een signed by the affending fo hould be detached for use as	by P	Part II. Other significant condi	tions contributing to de	eath but not resu	ulting in the un	derlying cause giv	en in Part I.	23e. Did	tobacco u	use contribute to t	the cause of death?
brd	w require been sig should b	ted							_ 1_	Yes 2	K No 3 □ Pro	bably 4 □Unknown
Records,	law as b 2 st	Completed							24a. Was	psy	24b. Were auto	opsy findings available ompletion of cause of
al F	ysician; The its certificate hadirector, page								perf 1□ Yes	ormed? 2 No	death?	
or Vital	sician; Th certificate rector, pag	Be	25. Was case referred to medic examiner?	Hospital:			3D DOA Oth	er.	Death (Check only			
o	Attending Physician: r death. ector: After this certific. by the funeral director,	년 2	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	of Injury	ER/Outpatient 28b. Time of	JUDON	4 LI Nursing	g Home 5 Res			fy)
ion	nding Ph th. r: After th e funeral	atior	1 XNatural 5 ☐ Pend 2 ☐ Accident inves	ing (Mona tigation	th, Day Year)	Injury	28c. Injur Wor M 1 □	rḱ? Yes 2 □ No			,	
Division	after death.  Director: /	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	I not be mined 28e. Place buildi	of injury - At ho	ome, farm, stre	et, factory, office		28f. Location (	(Street an	nd Number or Run	al Route Number,
	ital or irs aftu ral Di		_	1								
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the I Examiner: On the band mani	best of my kno asis of examina ner stated.	wledge, death tion and/or inv	occurred at the ti restigation, in my o	me, date and place opinion, death o	ace, and due to the ccurred at the time	cause(s) , date and	) and manner as a d place, and due t	stated. to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certif	er		-	29c. Licens	e number		29d. Da	te signed (Month,	Day, Year)
			/ Sogar	11/2		MID	0101	.7078 (V	/A)	Oct	- 26.2	007
1	4		30. Name and address of perso	who completed caus	e of death (Item	23a) (Type, F	Print)	NATIONA	L NAVAL			ER
P	'		RYAN T. MOOR	20 8	USA	1000	Service Designation	BETHESD	A MD 208	89-5	600	
	Sta Registr		GCT 3	1 2007	egistrar's Signa							

**Funeral** Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1 - State Registrar		,	Ce	ertificate of	Death	Reg	1. No.	1	348	81
Physici	an	1. Decedent's Name (First, Middle						2. Date of Death October	2ªy, ž	შნ7	3. Time of E	
/Medic	cal	Subrata Baner 5  4a. Facility Name (If not institution Shady Grove Adv	n, give street and nur			4b. City, Town, o	or Location of Death	October	4c. County of Montgo	Death	9:53	ам
Funeral Director		5. Social Security Number none	6. Sex 1 <b>X</b> M 2□ F	7. Age (In yrs. 8				8. Date of Birth (Month, Day, )	/ear) 9	. Birthpla	ice (State or	Foreign
-		Usual Residence of Decedent						11/21/19	019   1	ndia		-
show	'n	West 10b. County	nknown)	10c. City	y, Town or l			1 •		10	d. Inside City 1 ☐ Yes 2	
r 28a-f	Director	Bengal (U)	IIKIIOWII)		5	10f. Zip Code	looghly, I		g. Citizen of Wha		<u>Jnknow</u>	n)
23a ol ust be	al D	Latbagan Keo	ta				N/A		India			
Department of heatin and wenter hygiene. Importants if them 21a or 28a-f show important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☒ Widowed 4 □ Divorced	ried Armed Fo	<sup>2</sup> ∏No ∕e	S. 13	. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 27 No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		White, e		an
"natur dical	eted	15. Deceder (Specify only highe	it's Education est grade completed)		(Giv	edent's Usual Occup e kind of work done	during most of worki	ing 1	6b. Kind of Busin	ness/Indu	istry	
than the Me	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	Wri	DO NOT use retire ter	d) -	I	Publishi	ng		
other vent, t	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Name	(First, Middle, Ma	aiden Surname)	-		
narked narked	일	Sunit Kumar Bar					Nalini M					
27 Is no		19a. Informant's Name/Relations Shampa Srivastav		r	1		and Number or Rura 1 Ct. Gai		-		Code)	
I tem	- 31	20a. Method of Disposition		20b. P	lace of Disr	position (Name of ematory or other pla			Oc. Location - Cit		n, State	
tant: It		1 ☐ Burial 2 【Cremation 4 ☐ Donation 5 ☐ Other (5	Specify)			ke Cremat		7/2007 Be				
Impor any in		21. Signature of Funeral Service	hicensee huvan	M0038			<sup>ss of Facility</sup> Rap ve Silver				on Svc.	,
ysician Medical		23a. Part1. En or the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. A c	aused the death ach line. for as a consequ	Car	nter the mode of dyi	ng, such as cardiac o	or respiratory arres	t,		Approximate nterval Betwo Onset and De	en eath
aminer		Sequentially list conditions	b. Con	oreur	V	Arter	1 Dis-	ease			Mers	-
and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S . H	or as a consequ	chal	esterol	emia			(	Har	5
physician and as the burial-transit	Medical Ex	resulting in death) East	d. A	y ay a consequ	ience of):	abrill	ation	<u> </u>	-80	-	pla	B
Train 2- nous are occur. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as a completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live b	come pf pregna irth 2 ∐ Fetal ant at time of de own	death 3	□Ectopic pregnanc □ Other (specify)	y		23d. Date o Month		/ Day Ye	ar
in signed b	by	Part II. Other significant condition	ons contributing to de	eath but not resu	ulting in the	underlying cause giv	en in Part I.	23e. Did toba 1 ☐ Yes	cco use contribu 2 ☐ No 3[	ute to the	/	
page 2 sho	Completed	SICK SIN	us S	ynol	NO	W_		24a. Was an autopsy performe 1  Yes 2	prio ed? dea	or to com th?	sy findings av pletion of cau	
certific rector,	Be	25. Was case referred to medica examiner?	Hospital:			ont 3D DOA Oth	26. Place of Death					
t: After this tuneral di	ition: To	1 Yes 2 No  27. Manner of Death 12 Natural 5 Pendin 2 Accident investig	28a. Date (		ER/Outpation 28b. Time Injury	of 28c. Inju	4 LI Nursing Ho	me 5 ☐ Residen 28d. Describe how		(Specify)		
al Director	Certification:	3 Suicide 6 Could determ	ined Zoe. Flace	of injury - At ho ng, etc. (Specify		treet, factory, office		28f. Location (Stre City or Town,		or Rural	Route Numb	эг,
he Funer pletely fills	Medical	29a. Certifier 1 Certifylr (Check only one) 1 Medical	ng Physician: To the Examiner: On the ba and man	best of my know asis of examinat ner stated.	wledge, dea tion and/or i	ath occurred at the ti investigation, in my	me, date and place, opinion, death occur	and due to the cau red at the time, dat	ise(s) and mann e and place, and	er as sta d due to	ted. the cause(s)	
To t	Ž	29b. Signature and title of certifie	1/1/20	7 0 4	2.0	29c. Licens	e number	290	I. Date signed (/	Month, D	ay, Year)	
10	-	30. Name and address of person	who completed cause	e of death (Item	23a) (Tuna	Print)	670 19		0124	10	7	
Ψ		Nicole Veter  31. Date filed (Month, Day, Year)	e, MD	9901	Med	lical Cer	du Driv	e Silver	Spring	7, MT	308	50
Sta Registra		OCT 3 1 20		J. J.	Local	S. A.						

				of Maryland	-			nd Mental Hy	giene	7 01000
			1 - State Registrar		Cei	rtificate of	Death	0.00	Reg. No. LUU	7 34882
	Physici	an	1. Decedent's Name (First, Middle, Last)	TV				2. Date of De Month	Day Yea	3. Time of Death 12:23 pM
1	/Medic		4a. Facility Name (If not institution, give street and	I number)	-	4b. City, Town, o	r Location of	Death ( )	4c. County of De	
1	Examir	ler	Son Creek - C	PNESIS		Λ	colis		Anne f	frindel
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24		th 9.8	hirthplace (State or Foreign Country)
1.5	Director		233-48-4019 1XM 2	F 73	Yrs.	World Days	Tiodis	DEC. 8	B, 1933 N.	CAROLINA
	land ow it		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mary i-f sh fied a	to	MD ANNE ARUNDE	L / Z	ANNAE	OLIS				1 Tyes Z No
	th the or 28s e noti	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	23a ust b		2109 BAY DRIVE				401		U.S.	Α
	er deg items ner m	Funeral	Arme	Decedent Ever in U.S. I Forces?	13.	Was Decedent of H f Yes, specify Cuba	ispanic Origir an, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Ar Black, WI	nerican Indian, nite, etc.
36	rs aft I", or xami	by F	I If Van	es 2□ No , Give or Dates: 1956-	.59	1□Yes 2X No	Specify:		Specify: W	HITE
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	ted	15. Decedent's Education		16a. Deced	lent's Usual Occup	ation		16b. Kind of Busines	
218	ithin 7 ie. ian "r Med	Completed	(Specify only highest grade complete Elementary/Secondary (0-12) Colle	ea) ge (1-4or 5+)	life. I	kind of work done	1)	r working		
2	e filed wi al Hygier other th vent, th			5+	SALE	S ASSOC		- N - /5" + 45.4"	REAL E	STATE
anc	d be fi	Be	17. Father's Name (First, Middle, Last) HORACE L. BASS, SR					Name (First, Middle		
Maryland	2 should and Men is marke aumatic	မ	19a. Informant's Name/Relationship (Type. Print)	· · · · · · · · · · · · · · · · · · ·	19b. Mailir	g Address (Street			WATKINS per, City or Town, State	. Zip Code)
	1 and 2 Health a tem 27 is		ANNE BASS/ WIFE						, MARYLA	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fr	non	ce of Dispo	sition (Name of natory or other place	i	Date	20c. Location - City	or Town, State
ij	Pages ment of l tant: If its jury or o		4 □ Donation 5 □ Other (Specify)			ARET'S	CEMET	ERY 11/2	/07 ANNA	POLIS,MD
Bai	permit. Departr Importa any Inju		21. Signature of Functional Service Licensee		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	TLLY &	ZETĽE	R INC. F	UNERAL HO	OME
			23a, Part1, Enter the disease, or complications the	at caused the death.		JUI EAS	TEKN	AAFMOF, B	ALTIMORE,	MD. 21231 Approximate
	Physician		Part1. Enter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final)	on each line.	Hills					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	to (or a la consequer	nce of):	· CAC	MOME	-		(Marth
E	Examiner		Sequentially list conditions b.							
	pe tis	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a conse uer	nce of):					
	xecuti and II-tran	Examiner	that initiated events	to (or as a consequer	nce of):					
8760,	cate be executed physician and the burial-transit	dical E	d	,						
9	tificate g phy as the	ledic	u							
Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant	outcome pf pregnanc		Ectopic pregnancy	,		23d. Date of d	,
	ie dea the at ned fo	sici	1 Type 2 No. 4 P	regnant at time of dear		Other (specify)			Month	Day Year
P.0	hat the	Phy	Part II. Other significant conditions contributing	o death but not resulti	ng in the ur	nderiving cause giv	en in Part I	23e Did t	tohacco use contribute	to the cause of death?
Vital Records,	uires t signe	d by			.g	iddiiyiii <b>g</b> vaddo giv	on mr are i.	1 🗆		Probably 4 ☐Unknown
Ç	w require s been sign should b	Completed						24a, Was	an 24b Were	autopsy findings available
Be	The Is te has age 2	omp						auto	psy prior to death	o completion of cause of
<u>I</u>	siclan: The law certificate has t irector, page 2 s	Be C	25. Was case referred to medical examiner?				26. Place o	1  Yes f Death (Check only of		es 212 10
	hysic this ce	To	1 ☐ Yes 2 ☐ Hospital:		l/Outpatien		4 Nurs	ing Home 5 ☐ Resi	dence 6 □Other (Sp	pecify)
Division or	ding Phys T. After this funeral di	ion:	1 Natural 5 ☐ Pending (/	ate of Injury 28 Month, Day Year)	Bb. Time of Injury	Wor			how injury occurred	
S	l or Attencafter death Director:	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. P.	ace of injury - At home	e. farm. str		Yes 2 □ No		Street and Number or	Rural Route Number
<u>≤</u> .	pital or Attending Physician: The ours after death. eral Director: After this certificate ha filled in by the funeral director, page	Certification:	4 ☐ Homicide determined b	uilding, etc. (Specify)	o, rarri, ou	out, ractory, omeo		City or To		riara riodic rvariber,
	ospita hours unera ly fille		29a. Certifier 1 Certifying Physician: To							
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to make the funeral director, to the funeral director, to	Medical	one) and n	nanner stated.	n and/or in			occurred at the time,	, date and place, and d	ue to the cause(s)
	P TE US	2	29b. Signature and title of certifier	M		29c. Licens	e number	1570	29d. Date signed (Mo	onth, Day, Year)
7	0//		20 Name and address of source	augo of death (tree or	20) (T:::=:	Drint)	1006	ってってい	10/0	- Harry +
(_	15		30. Name and address of person who completed of	ause of death (Item 2	Ph.	e gw	Best	We Rd	Sule 300	OM appropria
v	Sta	te		2. Registrar's Signatur	e		-	,		21401
	Registr	ar	OCT 3 1 2007	A A	9 1					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Ctober 25, 2007 **Physician** 8:30 A Brian Patrick Buckley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 8. Date of Birth (Month, Day, Year) April 29, 1 7. Age (In vrs. last birthdav. 6. Sex **Funeral** Months Days Hours Min 1XM 2□F 38 **Director** 041-78-9684 1969 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Potomac Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 7855 Oracle Place 20854 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No White þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n any injury or other traumatic event, the Medical once. Elementary/Secondary (0-12) College (1-4or 5+) Manager Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Brian Patrick Buckley Esther Sarik 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther C. Oakes/Mother 7855 Oracle Place, Potomac, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State October Montgomery Crematorium Bethesda, Maryland 4 □ Donation 5 □ Other (Specify) 28, 2007 21. Signature of Funeral Service Licersee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Rockville, Inc. M01173 300 W. Montgomery Avenue, Rockville, Maryland 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Emboli /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Sepsis, Urinary Tract Infection, Glioblastoma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Multiforme, Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No cate has l autopsy performe certificate 1∐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 X No 2 ER/Outpatient 3 DOA Medical Certification: To 1 🔀 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

9 State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Hossein Akhondi, M.D.

OCT 3 1 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 32. Registrar's Signature

1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1)0062167

29d. Date signed (Month, Day, Year)

be of the modern member mix. Ensure An copies Are Legiple-	0.1
State of Maryland / Department of Health and Mental Hygiene	34

		1 - For State Registrar				nt of Health and te of Death		Reg. No.	707	34881	
Physic /Medi Examir	al	Decedent's Name (First, Middle, Li     Stephen     J     4a. Facility Name (If not institution, gi	Boyle	Jr.	4b. City	r, Town, or Localion of Deat	2. Date of Dea Month OCTODER	22 2	Year 2007 by of Death	3. Time of Death 1:50 PM	
Funeral Director		215-32-8858		yrs. last birthday) 70 Yrs.	If Under	Pasadena er 1 Year   If Under 24 Hrs Days Hours Min.		h	Anne Arundel  9. Birthplace (State or Foreign Country)  MD		
1Z15-UU36 within 72 hours after death with the Maryland ane. than "natural", or items 23s or 28s-f ehow he Madical Examinar must be notified at	ector	Usuel Residence of Decedent  10a. State  10b. County  Haryland Arine A  10e. Street and Number		c. City, Town or Lo		Pasadena				10d. Inside City Limits 1 ☐ Yes 2∑ No	
ath with 1 23a or 3	Funeral Director	104 Disney Avenu	е			ip Code 21122			itizen of Whal Country? USA		
NU36 ours after de rai", or items Exeminar n	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was DecedenI Ever Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Deci If Yes, sp 1 ☐ Yes	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer 2 No Specify:	Specify Yes or No- to Rican, etc.) 14. Hace - A. Black, W Specify:			can Indian, etc. 11†e	
Maryland 21215-UU36 nd 2 should be filed within 72 hours af th and Mantal Hyglane. 27 ie marked other than "natural", or traumatic event, the Madical Expan	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5+)	(Give	kind of w	ual Occupation ork done during most of wo use retired) Metal Worker	rking	Sh	Sheet Metal Fabrication		
laryland 212 2 should be filed within and Mental Hygiene. ie marked other than aumatic event, the M	To Be C	17. Father's Name (First, Middle, Las Stephen J.	Boyle Sr.			Cather		Dick			
		19a. Informant's Name/Relationship Stephen C. Boyle	(son)	7639	9 Bea	s (Street and Number or Ri Ich Drive, Pa	sadena,	MD 2112	22		
Daltimore, permit. Pages 1 ar Depertment of Hea important: if item any injury or other once.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Special Signature of Fig. Service Lice)	y)	ob. Place of Dispo cemetery, cred Metro Cre	emato	nd Address of Facility			re, M	aryland	
Deperiment of the party of the		1 Sild 2	ral H 1D 21	ome, P.A. 122							
Physician /Medical Examiner		23a. Part1. Enter the disbase, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the cone cause on each line.  a	car	ter the mo	de of dying, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death	
BOX 80/00, asth certificate be executed attending physicien and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Łast	b. Due to (or as a cord.  Due to (or as a cord.								
. 0 00	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic p	oregnancy pecify)		1	ate of deliver	ery Day Year	
he taw requires that the law requires to the the has been signed by the tige 2 should be deteched.	ted by Pr	Part II. Other significant conditions	contributing to death but no	t resulting in the u	nderlying	cause given in Part I.	iven in Part I. 23e. Did tobac		atribute to t	ne cause of death?	
The law The has b	e Comple	25. Was case referred to medical						med? 2 No	Were auto prior to co death? 1 \( \subseteq Yes	opsy findings available impletion of cause of	
_	To Be	examiner?	Hospital:	2 ER/Outpatier	nt 3□ D	Other	ath <i>Check</i> only o		her (Specif	iv)	
To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: Affer th completely filled in by the funeral	Certification:	27. Manner of D ath  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			М	28c. Injury al Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occu	rred		
To the Hospital or Al within 24 hours efter of the Funeral Directompletely filled in by	i Certif	4 Homicide determined	building, etc. (S)	oecify)		-	City or Tow	n, State)		al Route Number,	
the Hos in 24 hi the Fun pletely	Medicai	(Check only one)	niner: On the basis of examiner and manner stated.	mination and/or in	vestigation	d at the time, date and place n, in my opinion, death occu	rred at the time, o	date and place,	anner as s and due to	the cause(s)	
To t To t	Σ	29b. Signature and title of certifier	nz M.D			bc. License number 39505		29d. Date signo )cto be			
10+1		30. Name and address of person who Yudhi Sh M		(Item 23a) (Type,	Print)	D39505	Glen A	sum	ie,	MD 21061	
Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	9 9						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BULDEN Month Physician EMMA 200 /Medical 4a. Facility\_Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA SINAL HOSpita BACTIMORE Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) (0 = 28 32 Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2XF Months Days Couply RQUNIA 224.36.200 Hours Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show at MD. BALTIMORE NIA 1 Yes 2 □ No Examiner must be notified 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code MANOR DRIVE 21215 4552 WERBU 45 If item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must b Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: BLACK 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) EDUCATION Elementary/Secondary (0-12) College (1-4or 5+) TEACHERS AID 10 و س 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be Mental un known LANNIE ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4552 DERBY MANOR DR BALTIMORE MD ZIZIS permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra WETTA 20b. Place of Disposition (Name of cemetery, crematory or other place)

ACOUTUS MEM PK, 20c. Location - City or Town, State 20a. Method of Disposition Date 10/26/07 Burial 2 ☐ Cremation 3 ☐ Removal from State BACTINGRE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility PHellips fund Home. 21. Signature of Funeral Service Licensee CFSP. CPC 1721-27 N. MONKOEST. BACTIMORE, MD 2,217 hecta 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CUTE MYOCARDIVIL disease or condition resulting in death) innedule /Medical Due to (or as a consequence of): Examiner Nonay Ecquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hypercholeste and Due to (or as a consequence of) Records, P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ be rold 15M 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1□ Yes 2☑No Division or Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 2 ☐ ER/Outpatient 3 ☐ DOA 은 1 Inpatient this 28a. Date of Injury (Month, Day Year) funeral Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the l within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03037

Registrar
DHMH 17 Rev 1/2001

State

6503

Ave

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cooper

2007

M-

31. Date filed (Month, Day, Year)

MU)

32. Registrar's Signature

348	8	6
-----	---	---

Funeral Director    Social Security Number   S	eath  Itimore City  Birthplace (State or Foreign Country)  I owa  10d. Inside City Limits  1  Yes 2 No  Country?  J.S.A.  merican Indian,  thite, etc.  White		
Second Second	eath  Itimore City  Birthplace (State or Foreign Country) Iowa  10d. Inside City Limits 1  Yes 2 No  Country?  J.S.A.  merican Indian, hite, etc.  White		
Funeral Director    Social Security Number   6. Set   7. Age   In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Pay Year)   9. E.	Itimore City Birthplace (State or Foreign Country) I owa  10d. Inside City Limits 1  Yes 2 No  Country?  J.S.A. merican Indian, hite, etc.  White		
Funeral Director    Social Security Number   S	Birthplace (State or Foreign Country) Iowa  10d. Inside City Limits 1  Yes 2 No  Country?  J.S.A. merican Indian, thite, etc.  White		
Usual Residence of Decedent  10a. State  10b. County  DE  Sussex  Millsboro  10c. City, Town or Location  DE  Sussex  Millsboro  10c. City, Town or Location  DE  Sussex  Millsboro  10c. City Town or Location  DE  Sussex  Millsboro  10c. City Town or Location  Millsboro  10c. City Town or Location  Millsboro  10c. City Town or Location  Millsboro  10c. City Town or Location  Millsboro  10c. City Town or Location  Millsboro  10c. City Town or Location  Millsboro  10c. City Town or Location  Millsboro  10c. City Town or Location  Millsboro  10c. City Town or Location  10c. City Town or	10d. Inside City Limits 1   Yes 2   No  Country?  J.S.A. merican Indian, hite, etc.  White		
DE Sussex Millsboro  10a. State 10b. County DE Sussex Millsboro  10c. City, Town or Location  DE Sussex Millsboro  10d. Zip Code 1d.	1 □ Yes 2 No  Country?  J.S.A.  merican Indian, hite, etc.  White  ss/Industry		
The policy of th	Country?  J.S.A. merican Indian, hite, etc.  White ss/Industry		
The policy of th	J.S.A. merican Indian, 'hite, etc.  White ss/Industry		
The policy of th	merican Indian, thite, etc. White		
The policy of th	White ss/Industry		
The policy of th	ŕ		
The policy of th	Oil		
The state of the s			
Amelia Gaass  C. E. Buerkens  Amelia Gaass  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State			
19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State	· ·		
	e, Zip Code)		
	or Town State		
1 Burial 2 Picremation 3 Removal from State	more, MD		
21. Signature of Funetal Service Licensee 22. Name and Address of Facility			
3871 Old Columbia Pike Ellicott City, MD 210			
23a. Part 1. Enfect the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death		
Physician / Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Due to (or its a consequence of):	3 meeks		
Examiner	vears		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1/ 0 11 - 5		
The fame of the fa	y-eous		
dause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d. Due to (or as a consequence of):			
in the past 12 months?    Section   In the past 12 months   In the past 12 mon	23d. Date of delivery  Month Day Year		
1   Yes 2   No 9   Unknown 9   Unknown 9   Unknown 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributed			
	La		
1 Yes 2 No 3			
nadormed?			
1 Yes 24 No 1 Yes	es 2□No		
25. Was case referred to medical examiner?  1 Yes 2 No Hospital:   Inpatient   2 ER/Outpatient   3 DOA   Other: 4 Nursing Home   5 Residence   6 Other (S)   1 Nursing Home   5 Residence   6 Other (S)   1 Nursing Home   5 Residence   6 Nursing Home   5 Nursing H	pecify)		
25. Was case referred to medical examiner?  1   Yes   2   No   Hospital:   Inpatient   2   EP/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (S)    27. Manner of Death   Nursing Home   5   Residence   6   Other (S)    28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes   2   No   Yes   2			
27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28b. Time of Injury M 28b. Time of Injury M 28b. Time of Injury M 1 Yes 2 No 28b. Discribe how injury occurred 28c. Injury at Work? 1 Yes 2 No 28b. Discribe how injury occurred 28c. Injury at Work? 1 Yes 2 No 28b. Place of Injury M 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28b. Discribe how injury occurred 28c. Injury at Work? 28b. Discribe how injury occurred 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work?	Rural Route Number,		
	ne statue		
29a. Certifier (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and do and manner stated.	lue to the cause(s)		
and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Mc			
1 53391 October	29, 200/		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ming Vi MD 3320 Bens (n Avenue, Bultimore, Marylo  State 31. Date files (Month, Day, Year)  32. Agistrar's Signature	md 21227		
State 31. Date filed (Month, Day, Year) 32 Pagistrar's Signature			

07-08184 Christopher Jame	es C	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene
	1	For State Certificate of Death
Physicia	n/	Decedent's Name (First, Middle,Last)  2. Date of Death  3. Time of Death
Medical Examir		Christopher James Capperella October 20, 2007 2002 1118
		La. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  University Hospital  Baltimore
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director		220-72-9013 1XM 2 F 33 Yrs. Months Days Hours Min. 6/17/1974 Foreign Country) Maruland
	ļ	Jsual Residence of Decedent
ow any		0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No
yland a-f she t once	흱	0e, Street and Number 10f, Zip Code 10g, Citizen of What Country?
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	uneral Director	5421 Canonbury Road 21237 USA
with the same se noti	la	1. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
death or iten	nu	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
s after ral",	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify
2 hours after "natural",  Examiner	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)
036 Ithin 7. ne. r than	Completed	Signs & Markoting Tech 1 Department of Transportation
5-0 fled wi Hygie I other		17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
121 Id be fi fental narked	o Be	9a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	۲	Lisa Friia - Friend 3727 Double Rock Lane Parkville Md 21234
e, N 1 and 1 and Health item	ı	20a. Method of Disposition
MOF Pages ent of imt: If		1 V Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:  MT Pleasant Cemetery 10-29-2007 Finks by ca. Md.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Ì	21. Signature of Funeral Service Licensee  22. Name and Address of Fricility  23. Name and Address of Fricility  24. Name and Address of Fricility  25. Name and Address of Fricility  26. Name and Address of Fricility  27. Name and Address of Fricility  28. Name and Address of Fricility  29. Name and Address of Fricility  20. Name and Address of Fricility  21. Name and Address of Fricility  22. Name and Address of Fricility  23. Name and Address of Fricility  24. Name and Address of Fricility  25. Name and Address of Fricility  26. Name and Address of Fricility  27. Name and Address of Fricility  28. Name and Address of Fricility  29. Name and Name and Name and Name and Name and Name and Name and Name and Na
		San Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
Physician /Medical		failure. List only one cause on each line.  Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):
Trans		Sequentially list conditions, b
	nine	f any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause
outed nd iransit	Examiner	Due to (or as a consequence of):
executed an and al - transi		d.  UNPENDED X AMENDED TH -872 10/31/07 TT
60, ate be a hysiciz	Medi	UNPENDED X #F, perFH, g872, 10/31/07 TT  F FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
68760, certificate be nding physici	Physician/Medica	3b. Was decedent pregnant in the past 12 months?   1 Live birth   2 Fetal death   3 Ectopic pregnancy   Month Day Year
SOX Jeath c	ysic	1 Yes 2 No 9 Unknown g Unknown
O. E at the d		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Division of Vital Records, P.O. Box 68760, rel or Attending Physician: The law requires that the death certificate by safter death.  al Director: After this certificate has been signed by the attending physical in the funeral director, page 2 should be detached for use as the but	d by	1 Yes 2 No 3 Probably 4 V Unknown
ords w requisions been should	plete	24a. Was an autopsy findings available autopsy prior to completion of cause of
Reco	Completed	performed? death?  1  Yes 2 No 1  Yes 2 No
tal I	Be	25. Was case referred to medical examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other:  Other:
of Vi	P	77. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
on Control of the function	Certification:	1 Natural 5 Pending Oct 20, 2007 Pending 1841 hrs 1 Yes 2 No Subject driver of vehicle struck by train
ViSic or Atte fler des oirecto	fica	2 Maccident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Di spital cours at	Cert	4 Homicide determined (Specify) railroad track Schaefer Lane / Pulaki Highway , Baltimore , MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executifing the bound of the Funeral Director: After this certificate has been signed by the attending physician at completely filled in by the funeral director, page 2 should be detached for use as the burial -1		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
( ) 15 ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
	-	O.C.M.E. OCME October 21, 2007
	}	Modern M., New Market and address of person who completed cause of death (I)em 23a)
2		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
St Regist	ate	31. Date filed (Month, Day, Year)  32. Régistrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. ZU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3:35 P<sub>M</sub> DCMOBER Day7 **Physician** 过即07 IMIN /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death i more 4b. City, Town, or Location of Death Examiner Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗷 F 47-32-2168 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with Hygiene. 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Ex miner must be in )SI Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify <u>^</u> Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 onemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) B ဥ  $\Omega$ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Indrew 2920 Knoll Hores Drive 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Toseph's Fullenten Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 11-2-2007 Baltimore emetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funerry Chapel + Cremation Services lacu 8800 Harford Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) URD SEPSIS **Physician** /Medical Due to (or as a consequence of): ADVANCED JACOB - CREUTZFELDT DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 4 Unknown cate has been signated by page 2 should b 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed' 2□No 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 17 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No nours after death.
neral Director: A death. 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or To the Hospital within 24 hours a To the Funeral L Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

١0

State Registrar 29b. Signature at

d title of ce

rtifier

KOKOTAKIS **EMANUEL** JOSEPH 31. Date filed (Month, Day, Year) OCT 3 1 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D. 32. Registrar's Signature

29c. License number D56@3@ 29d. Date signed (Month, Lay, Year)

7601 OSLER DRIVE TOWSON, MARYLAND 21204

			1- State of Maryland / Department of Health and Maryland / Department of Death  Certificate of Death	Mental Hyg	iene2007	34889								
			1. Decedent's Name (First, Middle, Last)	2. Date of Deat	h	3. Time of Death								
	Physici /Medio		William T. Cavanaugh	October	Day Year 27, 2007	8:30 A M								
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dea									
			Citizen's Care Health & Rehab. Havre de Grace	9	Harf	ord								
	Funeral		5. Social Security Number  6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	Year) 9. Bi	rthplace (State or Foreign ountry)								
	Director		330-12-4713 85 Yrs.	Nov. 30	, 1921	Illinois								
	pue w		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location			10d. Inside City Limits								
	laryli sho	5				1 ☐ Yes 2 🔯 No								
	28a-	Director	Maryland Baltimore White Marsh  10e. Street and Number 10f. Zip Code	1	0g. Citizen of What C	ountry?								
	with Ba or				U. S.									
	ns 23	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Am	erican Indian,								
မွ	after or Item	Funeral	1 Never Married 2 Married   1 ☑ Yes 2 No 1942-	Rican, etc.)	Black, Wh	ite, etc.								
Ö	al', o	þ	3 ☑ Widowed 4 □ Divorced   If Yes, Give Year or Dates: 1946   1 □ Yes 2 □ No Specify:		Specify: W	hite								
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28e-f show I.e Medical Everili or Linal Le Incillia a	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work	kina	16b. Kind of Business	s/Industry								
2	ithin Ben "	npie	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	9										
2	ygier ygier her th		12 Design Engineer	(27) - 44:10	Martin Ma	rietta								
Maryland	12 should be filed within "h and Menta! Hygiene. 7 Is marked other than "fraumatic event, IL a Me.	Be		ne (First, Middle, I	Maiden Surname)									
3	d Mer nark	P	200 00100000	Werner	Character Character	Tin Code)								
Mai	12 st h and 7 Is r traur		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru  19c. Name/Relationship (Com)											
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-1 show Item 27 Is marked other than "natural ke notified at		Peter Cavanaugh (Son) 5408 Bush St., White 20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City o									
nor	nt of nt of t: If It		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)											
Baltimore,	artme artme ortani Injury		*4 Donation 5 Other (Specify) Moreland Memorial 10/29/2007 Baltimore, Maryland  1. Signature of Funeral Service Ligensee 222. Name and Address of Facility Schimunek Funeral Home Inc.											
Ba	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra ance.		9705 Belair Rd., No											
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one caus on each line.	or respiratory arre	est,	Approximate Interval Between Onset and Death								
	Physician		Immediate Cause (Final disease or condition			Onset and Death								
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):											
		e.	Sequentially list conditions, b. Lue to (or as a consequence of):											
	ted nsit	nju	fl any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
	and al-train	Examin	resulting in death) Last Due to (or as a consequence of):											
8760,	cate be executed physician and the burial-transit	dicai E	a periphere vosantar disence											
9	ifficati g phy as the	edic												
Вох	eath certific attending pl	N/U	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			d. Date of delivery								
	The law requires that the death certifi lie has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months / 4 Pregnant at time of death 5 □ Other (specify)		Month	Day Year								
P.0	at the de I by the a stached i	Phy	3 Clouknown											
	es tha igned I be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?								
ord	w requir been s should	ted	Cornary or any of sease	1 🗆 Y €	es 2 No 3 F	robably 4 Munknown								
Records,	e law has b	Completed	1	24a. Was a autops	y prior to	utopsy findings available completion of cause of								
_		Co		perform	ned?/ death? 2 ☑ No 1 ☐ Ye	s 212 No								
Vital	Physiclan: The this certificete ral director, pag	Be	examiner?	th (Check only on	θ)									
o	Phys this ral dir	T.	1 ☐ Yes 2 ☑ No ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ 4 ☐ Nursing H  27. Manyer of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ence 6 Dother (Spanion of Courted)	ecify)								
O	ding Pt h, After th funeral	tion	1 Natural 5 Pending (Month, Day Year) Injury Work?	200. 2000/100 110	w injury document									
Division	or Attending after death, Director: Afte in by the fune	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (St	reet and Number or F	Tural Route Number,								
S	al or A safter I Direc d in by	Certification:	4 Homicide building, etc. (Specify)	City or Town	n, State)									
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only (Ch	, and due to the carred at the time, di	ause(s) and manner a ate and place, and du	is stated. e to the cause(s)								
	vithin 2, To the F complet	Med	one) and manner stated.  29b. Signature and title of certifier 29c. License number		9d. Date signed (Mor									
N.	7 × 7 8		NIII co co de la la la la la la la la la la la la la	-	10/29/2	,, ,								
1	7		39. Name and address of person who completed cause of death (Item 23a) (Type, Print).		1 701									
5			He Glith Sim 319 S. Mulin Ave Hab	MD	21078									
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		· · · · · · · · · · · · · · · · · · ·									
	Registr	ar	OCT 3 1 2007 Januar D. Januar											

			Please T	ype or Print in Blac					_	,	
			For State Registrar	State of Maryland / [	•	nent of Hea cate of De		Mental Hy	rgiene Reg. No. 200	7 31,000	
No.			Decedent's Name (First, Middle, Last)	)				2. Date of D	eath	3. Time of Death	
	Physici /Medi		Mary Caroline (					Octobe	er 29, 2007		
	Examir	ier	4a. Facility Name ( <i>If not institution, give</i> : <b>Stella Maris</b>	street and number)	4b.	City, Town, or Lo		h	4c. County of De		
	Funeral	20.	5. Social Security Number 6. Sex	, , , , , , , , , , , , , , , , , , , ,		Under 24 Hrs		Baltimore  9. Birth 9. Birthplace (State or For			
	Director		220-48-8893	M 2⊠F 55	Yrs. Mo	nths Days F	Hours Min.	April		Maryland	
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location	n	-			10d. Inside City Limits	
	e Man la-f sh tified	ctor	MD Baltimor	re Kings	ville					1 □ Yes 2 💢 💢 o	
	vith th	Director	10e. Street and Number			of. Zip Code			10g. Citizen of What C	Country?	
	eath v	Funeral	7438 Bradshaw Roa	12. Was Decedent Ever in U.S.	13 Was I	21087	anio Origin? /S	Innaifu Vac or N	USA - 14. Race - Am	orioan Indian	
39	be filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Decedent of Hispa i, specify Cuban, I ′es XX No S	Mexican, Puer Specify:	to Rican, etc.)	Black, Wh	ite, etc.	
2-0	72 hou natura Ilical E	Completed	15. Decedent's Edu (Specify only highest grade	cation 16a.	Decedent's	Usual Occupatio	n na most of wo	rking	16b. Kind of Busines	s/Industry	
121	within ene. than "		Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	OT use retired)		iking	Johns Hop		
d 2	filed vi Hygie		17. Father's Name (First, Middle, Last)		LIDIA	ry Assis		ne (First, Middle	Universit	У	
Maryland 21215-0036	should be and Mentai s marked o umatic eve	To Be	Walter T. Kirb	y			Marie	J. Reich	nart		
Man	l 2 sho n and ris ma	-	19a. Informant's Name/Relationship (Type						er, City or Town, State,	Zip Code)	
	iges 1 and 2 should it of Heaith and Mer If item 27 is marke or other traumatic		Grayson W. Corbir 20a. Method of Disposition	20b. Place of	Disposition	adshaw R	Road, K	ingsvill Date	Le, MD. 21 20c. Location - City of	087	
mo	Pages nent of F int: If ite ury or of		1 ☐ Burial 2 【XCremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State 1		y or other place)	10/	31/2007			
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Fune al Service License		22. Nar	ne and Address o	f Facility R	uck Tows		Home, Inc.	
	90 = 8 9		sliple (			O York R				21 204	
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	le cause on each line.	ot enter the	mode or dying, s	uch as cardia	or respiratory a	ırrest,	Approximate Interval Between Onset and Death	
F	/Medical		disease or condition resulting in death)	LUNG CANCER  Due to (or as a consequence of	of):						
П	Examiner	_	Sequentially list conditions, b								
T	executed and al-transit	xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	11):						
oʻ	Ψ Ξ.Ξ	ш	that initiated events resulting in death) Last	C. Due to (or as a consequence of):							
68760	eath certificate be e attending physician for use as the burie	dical	<b>€</b> d								
Box 6	certifii ding p	/Me	IF FEMALE: 23b. Was decedent pregnant 25	3c. If yes, outcome pf pregnancy					22d Date of d	1	
B	The law requires that the death certificate be the has been signed by the attending physicis age 2 should be detached for use as the but	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 📆 No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		pic pregnancy er (specify)			23d. Date of de Month	Day Year	
P. 0	that the death ed by the atte detached for	Phy	9 ☐ Unknown  Part II. Other significant conditions con		the condense	ing course sives in	- Dod I	00- Fide			
Records,	uires tha signed I	d by	Tarrii. Ottor significant conditions con	and the control of th	trie underly	ing cause given in	iraiti.		obacco use contribute Yes 2 ☐ No 3 ☐ F	Probably 4XJUnknown	
COL	law requir as been s 2 should	Completed						24a. Was		utopsy findings available	
Ä	The lav ate has page 2	mo				-		auto perfo 1□ Yes	prior to death? 2 No 1 □ Ye	completion of cause of	
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	agaital.			. Place of Dea	th (Check only o		20110	
ō	Phys r this ral dir	은	1 Yes 2X No 7	ospital: 1 ☐ Inpatient 2 ☐ ER/Out  28a. Date of Injury 28b. T			4 Nursing H		dence 6 X Other (Sp.	ecify) HOSPICE	
Division or Vital	Attending Physician: The probability of death.  rector: After this certificate he by the funeral director, page	cation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ju <b>ry</b> M	28c. Injury at Work?	2 □ No	200. Describe	now injury occurred		
DIV	Hospital or Attenc 24 hours after death Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, far building, etc. (Specify)	m, street, fa	actory, office		28f. Location ( City or To	Street and Number or F vn, State)	Rural Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical (	29a. Certifier (Check only one) Certifying Phys 2 Medical Examin	ician: To the best of my knowledge, ler: On the basis of examination and and manner stated.	death occu	arred at the time, of ation, in my opinion	date and place on, death occu	, and due to the irred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)	
	To the I	Me	29b. Signature and title of certifie			29c. License nu			29d. Date signed (Mon		
			1.			194	3725		10/29	107	

12

DR. TARIQ MAHMOOD

State 31. Date filed (Month, Day, Year)

32. 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

32. Registrar's Signature

Registrar

Registrar DHMH 17 Rev 1/2001

State

6

22

10201

2007

31. Date filed (Month, Day, Year)

My

32/Registrar's Signature

· Bhoo

07-08329 Diane Rita Collins

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2	0	0	7	34	8	9
---	---	---	---	----	---	---

arie rata Comin		For State	Cei	rtificate of	Death			Reg. No.	200	7 34036	
Physicia		. Decedent's Name (First, Middle,Last					Date of De     Month	Day Y	ear 3.	Time of Death 1020 hrs	
⊸ical Examir	ner	Diane Rita Col	lins					26, 2007	ty of Death	1020 1110	
	4	a. Facility Name (if not institution, give		,	4b. City, Town, or L Rosedale	_ocation of L	Death		ore Count	v	
		5 Maidstone Court Apartm		loot hirthday)	If Under 1 Year	If Under 2	24Hrs. 8. Date of	Birth (MM/DD/YY	YY) 9. Birthp	lace (State or	
Funeral		. Social Security Number 6. Se			Months Days		Min.		Foreign	rv)	
Director	L		M 2 XF 5	4 Yrs		لـــــــــــــــــــــــــــــــــــــ		28/195	2	"" MD	
8	<u> </u>	Jsual Residence of Decedent  10a, State 10b, County	10c. City	, Town or Locat	ion				10	0d. Inside City Limits	
ow any		MD Baltim	oro Po	sedale					1	Yes 2X No	
yland -f sh	핡	10e, Street and Number	ore ko	seuare	10f. Zip Code			10g. Citizen of	What Country	y?	
ith the Maryland 23a or 28a-f show notified at once.	įį				21237	,		USA			
vith th	Funeral Director	5 Maidstone Ct	12. Was Decedent Ever in U	J.S. 13. Wa	as Decedent of His	panic Origin	? ( Specify Yes or	No- 14. R		n Indian, Black,	
death with the Maryland ritems 23a or 28a-f shunst be notified at once	1 Never Married 2 Married 1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								/hite, etc.		
fter de l'', or	3 Widowed 4 X Divorced of Yes, Give Year or Dates:  15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Busing Specify: 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Busing Specify: 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Busing Specify: 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Busing Specify: 15 Decedent's Usual Occupation (Give kind of work done 16b. Kind of Busing Specify: 15 Decedent's Usual Occupation (Give kind of work done 16b. Kind of Busing Specify: 15 Decedent's Usual Occupation (Give kind of work done 16b. Kind of Busing Specify: 15 Decedent's Usual Occupation (Give kind of work done 16b. Kind of Busing Specify: 15 Decedent's Usual Occupation (Give kind of work done 16b. Kind of Busing Specify: 15 Decedent's Usual Occupation (Give kind of work done 16b. Kind of Busing Specify: 15 Decedent's Usual Occupation (Give kind of work done 16b. Kind of Busing Specify: 15 Decedent's Usual Occupation (Give kind of work done 16b. Kind of Busing Specify: 15 Decedent's Usual Occupation (Give kind of work done 16b. Kind of Busing Specify: 15 Decedent's Usual Occupation (Give kind of work done 16b. Kind of Busing Specify: 15 Decedent										
hours afte 'natural'', Examiner	g b	15. Decedent's Education (Specify or	f Business/ind	ustry							
6 172 h an "n cal E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  Legal File Clerk Legal									
5-0036 led within 72 Hygiene. I other than 'the Medical	12 18. Mother's Name (First, Middle, Last)										
filed Hyged off		•				Rita	Caroly	n (GRZ	ECHOW:	IAK)	
2121 buld be fi Mental marked ic event,	To Be	Charles Robert 19a. Informant's Name/Relationship (1	ype, Print )	19b. Mailir	ng Address (Stree	et and Numb	er or Rural Route	Number, City or	Town, State, 2	Zip Code)	
b, MD 21215-0036 and 2 should be filed within 72 hours after feath and Mental Hygiene. tem 27 is marked other than "natural", or traumatic event, the Medical Examiner.	-	Rita Carolyn V	itali Mothe	r 4 L	ongview	Dri	ve, Oce	Ocean View DE 19970  Date   20c. Location - City or Town, State			
e, N l and Health item	- 4	20a, Method of Disposition	200	. Place of Dispo crematory or o	SILION (Name of co	motory,					
imore, MD 2121. Pages I and 2 should be finent of Health and Mental I ant: If item 27 is marked or other traumatic event,		1 Burial 2 X Cremation 3 4 Donation 5 Other Specify	1 171	etro C	remator	·y	10/30/0	7 Ba	ltimo	re	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	ı	2 Junature of Funeral Service Licer			Name and Addres		Cvach /	Roseda	le Fu	nerl_Home	
M F P III	f			[1	211 Che	saco	Ave. R	osedal	e MD	21237 Approximate Interval	
Physician		23a. Part I. Enter the disease, or comfailure. List only one cause on e	olications that caused the dea ach line.	th, Do not enter	the mode of dying	, such as ca	ilidiac or respirators	arrest, shook, t	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Between Onset and Death	
'Medica'. _xaminer		Immediate Cause (Final disease a or condition resulting in death)	Lung cancer  Due to (or as a consequence	-4).							
		b	•	: 01).							
	ier	if any, leading to immediate	Due to (or as a consequence	e of):							
	Examin	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence	e of):							
ted J ansit		events resulting in death) Last		,							
760, icate be executed physician and the burial - transit	edical	X UNPENDED	AMENDED PII, 27, pe	r ME. 087	- '3 <b>\1</b> /6/07 '	TT					
60, ate be ex ohysician	≥	IF FEMALE:	23c. If yes, outcome of pr						ate of delivery	Day Year	
687 ertific ding p	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth  Pregnant at time of			Ectopic	pregnancy	IVIO	nth D	ay rear	
P.O. Box 687 s that the death certific gred by the attending p e detached for use as th	Physician/	1 Yes 2 No 9 V Unknow	4	death 5	Other (Specify)			_			
by the diched	F	Part II. Other significant conditions	contributing to death but no	ot resulting in the	e underlying cause	given in Pa				the cause of death?	
, P.O.	ğ	Chronic obst <u>ructi</u>	ve pulmonary dise	ase (COPI	))		1			pably 4 V Unknown	
ords, w require	Completed by							Was an autopsy	prior to c	topsy findings available completion of cause of	
COF law r has b	直							performed? Yes 2 ✔ No	death?	es 2 No	
tal Rection: The certificate ector, page	🞖	25. Was case referred to medical			26.Pla	ce of Death	(Check only one)				
Vital Recc ysician: The lav his certificate ha director, page 2	B B	examiner?	Hospital: 1 Inpatient 2	ER/Outpatie	ent 3 DOA	Other <sub>4</sub>	Nursing Home	5 Residence	e 6 🗸 Other	:: Scene	
Division of Vital Records, rat or Attending Physician: The law requirman shard reath.  Find Directors. After this certificate has been simpled in by the funeral director, page 2 should be	<u>ا:</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time	of Injury 28c. In	jury at Worl	(? 28d. Desc	cribe how injury	occurred		
on on ath.	흲	1 X Natural 5 Pending 2 Accident Investiga			_	Yes 2					
ivision or Attene after death Director:	iji	2 Accident Investigated 3 Suicide 6 Could not	28e Place of Injury - A	At home, farm, s	treet, factory, office	building, e		tion (Street and own, State)	Number or Ru	ural Route Number, City	
Div Dital o	Certification:	4 Homicide determin	(-6)								
Division of Vital Records, P.O. Box 68760, To the Inspiral or Attending Physician: The law requires that the death certificate be within 24 hours after death.  The thin Law of the thin Certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	<u> </u>	29a. Certifier (Check only) Certifying Phys	ician: To the best of my know er:On the basis of examination	rledge, death oc	curred at the time,	date and pl on, death or	ace, and due to the ccurred at the time,	e cause(s) and r , date and place	nanner as stat , and due to th	ec. ne cause(s)	
To the To the Complex	Medical	- 2:	and manner stated.	- Tanarar invade		nse number				onth, Day, Year)	
	≥	29b. Signature and title of certifier		1.6	1	C.M.E.		Octob	er 27, 200	7	
		unex	For UNG								
1		30. Name and address of person what Ling Li, MD Assistant	o completed cause of death ( Medical Examiner 1	iem 23a) 11 Penn St	reet, Baltimore	e, MD 21	201				
U	200	31 Date filed (Month, Day Year)	32, Registrar's Sig	nature	Argallo 1						
Regi	State	ר פייוון	2007 January	See Ja	-						

				State of Ma						-		egible.		
			For State Registrar		С	ertificat	te of l	Death		F	Reg. No.	200	1 3	489
	Physicia /Medic	_	Decedent's Name (First, Middle, La  Vance Nichols Ca:							Date of Dea Month Octobe	Day Year 9.55 AM			
Examin				4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death					ounty of Deatl	1	
•			4977 Battery Lan	e #1020				Bethe				ntgome	ry	
	Funeral Director		212-20-1282	Sex 7. Age	(In yrs. last birthda 81 Yrs	Months	r 1 Year Days	If Under Hours	24 Hrs. 8 Min.	. Date of Birtl (Month, Day 08/16	h / Year) <b>/ 1926</b>	9. Birtl	iplace (Sta. intry)	te or Foreign
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location							10d Inside	e City Limits
r 28a-f shov		ō			Betheso									res 2 ☐ No
		Director	MD Montgor  10e. Street and Number	nery	Betnesc		p Code			1	10a. Citize	n of What Co	untry?	
	with 3a or 1 be	۵		- #1020		1	0814-					ed Sta	-	
	ns 2%	Funeral	4977 Battery Lan 11. Marital Status	12. Was Decedent E	ver in U.S. 1	3. Was Dece	edent of H	ispanic Ori	gin? (Speci	fy Yes or No-	. 14	. Race - Ame		1,
200	urs after o	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  TXXYes 2 □ N  If Yes, Give  Year or Dates:	WWI	If Yes, spe 1 ☐ Yes		Specify:	ň, Puèrto Ri	can, etc.)	s	Black, White pecify: Wh		
5	72 ho	ted	15. Decedent's E	ducation	16a. De	cedent's Usu	ual Occup	ation	4 - 6			of Business/	-	
parifiliore, Marylatina Z.1.2.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5-	life	ive kind of w e. DO NOT t	ise retired	duning mos d)	t of working	-	Rea:	l Estat	:e	
		ပ်		51	. Att	orney								
		Be	17. Father's Name (First, Middle, Last	")				18. Mothe		First, Middle, cnown)	Maiden Si	urname)		
		은	Vance Caskey	(T. D.)										
Wich I		19a. Informant's Name/Relationship  Renate M. Caskey/	**								Town, State, 2 , MD 20			
ů,	Healther ther		20a. Method of Disposition		20b. Place of Di	sposition (Na	me of	- ;	Dat	te		ation - City or		9
ages int of the		1 ☐ Burial 2 【XCremation 3 [		cemetery, o	crematory or	other plac	, i	0	ct 17		sville			
all III o	it. Pa urtmen urtant: njury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Chesap									
0	Department once		Start A Lat		00332		Fune:	ral &	Cremat	tion Se	rvice g, Ma	s ryland	20910-	-
R	9		23a. Part1. Enter the disease, or con	nplications that caused	the death. Do not			-				-	Approxi	mate
	Physician		shock, or heart failure. List only Immediate Cause (Final			nol E	1					1		Between and Death
ŀ	/Medical		disease or condition resulting in death)	a.	Stage Re	ilai Fa	allui	e						
	Examiner				ertensive	Card	iovas	cular	Dise	ease				
724	\$	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	V	consequence of).									
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c											
oC,	e exe ian ar irial-t		resulting in death) Last	Due to (or as a	consequence of):									
00/00	ate by hysicathe by	lical		<b>_</b> d										
	ertific ling p	Physician/Medic	IF FEMALE:	20- 14										
X D D	eath c attend for us	ian/	23b. Was decedent pregnant in the past 12 months?		2 🗆 Fetal death	3 □Ectopic		/			23	ld. Date of del Month	ivery Day	Year
5	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	ume or death	5 ∐ Other (s	specity) <u> </u>							
ř.	that ted by		Part II. Other significant conditions	contributing to death bu	t not resulting in th	e underlying	cause giv	en in Part I		23e. Did to	obacco use	e contribute to	the cause	of death?
records,	uires sign Id be	d by	Coronary A	rtery Dise	ase					10	Yes 2	No 3∏Pr	obably 4	Unknown
Ö	и req beer shou	ete		-						24a. Was	an	24b. Were au	stoney findi	ngs available
֖֖֖֖֝֝֝֝֝֟֝֝ ב	he lav e has ge 2	Completed								autor	psy ormed?	prior to death?	completion	of cause of
[a	n: T ficate or, pa	င်	25. Was case referred to medical	1				00 81	( D 4 b - 1	1□ Yes	2 XNo	1 □ Yes	2□ No	
>	sicia s cert irectc	o Be	examiner?	Hospital:	nt 2 ☐ ER/Outpa	tient 3 🗆 🗈	OA Oth	er.		Check only o		DOther (Coa	aif d	
5	Phy er this eral d	<del> </del>	27. Manner of Death	28a. Date of Injur	y 28b. Tim	e of	28c. Injui Wor	4 🗆 14		Bd. Describe I		Other (Spe occurred	city)	
5	riding ifn. r. Afte e fune	Certification:	1XXNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	<i>Year)</i> Inju	ry M		ƙ? Yes 2 □	No					
212	Atte	ifice	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home, farm	street, facto	ry, office		28	If. Location (S	Street and	Number or Re	ural Route	Number,
5	s afte	Sert	7	pullating, etc	. (Openiy)					Ony 01 101	wii, Glale)			
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Cirector, After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	edical (		hysician: To the best of miner: On the basis of and manner sta	examination and/o									ıse(s)
	To th Withir To th	Me	29b. Signature and title of certifier			2	9c. Licens	e number			29d. Date	signed (Mont	h, Day, Yea	ar)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Francine A. Higgs-Shipman M.D.; 1533 Piccard Dr. #100, Rockville, MD

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

D28079

October 23, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Sondra October 22 arr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center

Social Security Number | Sex | 7. Age (In 17. lage Glen Burnie Anne Arunder If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 ☑ F 220-30-5458 March 27 1936 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County r 28a-f she notified a 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code o e 2244 Melvin Drive r than "natural", or Items 23a the Medical Examiner must b 21122 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a amy Injury or other traumatic event, the Medical Examiner must a once. USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Household 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Ε. ပ Doris Mettee Μ. Kane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edward L. Carr Jr (spouse) 2244 Melvin Drive, Pasadena. MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 2007 Baltimore, Maryland 21. Signature of Funeral Service Lic Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician anoxic encephalonathe 6 days /Medical Examiner Myocardi Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner ing physician and e as the burial-transit CUYLNGLY Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician a for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the a Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed s after death.

I Director: After this of in by the funeral d within 24 hours a

To the Funeral I

completely filled

1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown	World Day real						
hypertension,	diabetics, chronic rand insufficiency,	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ √ 0 3 ☐ Probably 4 ☐ Unknown						
sleep a pmoa, be	ecit canag	24a. Was an autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No						
25. Was case referred to medical	26. Place of Death (Check only one)							
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work?  1  Yes 2 No	28d. Describe how injury occurred						
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)						

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jacohs MD

29c. License number

Glen Burnie, mp 2104

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) October 22, 200)

State Registrar

Medical

31. Date filed (Month, Day, Year) **OCT** 3

29b. Signature and title of certifier

29a, Certifier

305 Nuipital 32 Registrar's Signature

and manner stated.

	1	For State Registrar	State o	f Marylar	nd / Depa <i>Cei</i>	artment of F rtificate of	lealth and Death	Mental Hy	giene Reg. No.	2007	34895	
Physicia /Medica	n	. Decedent's Name (First, Middle, Betty	Last) Jane		Calde	^		2. Date of De Month	Day	Year	3. Time of Death	
Examine		a. Facility Name (If not institution, g Harbor Hospita		mber)			r Location of Dea	th	4c. (	County of Deat	n N/A	
Funeral Director		Social Security Number 6.19-28-5867	.Sex 1□M 2☑F	7. Age (In yrs.	76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		ay, Year)	9. Birt Co	hplace (State or Foreign untry) WV	
aryland show	_ 1	Jsual Residence of Decedent  0a. State 10b. County	A.a	10c. Ci	ty, Town or Lo						10d. Inside City Limits 1 □ Yes 2 ☒ No	
with the Mia or 28a-f	Direc	Maryland Anne Oe. Street and Number 3520 Mountain F	Arundel Road			10f. Zip Code	asadena		10g. Citiz	zen of What Co	puntry?	
	by Funeral	1. Marital Status  1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	12. Was Dec Armed Fo	2 🛛 No ve		Was Decedent of H If Yes, specity Cub 1 ☐ Yes 2 ☒ No		Specify Yes or Norto Rican, etc.)		14. Race - Ame Black, White	rican Indian,	
within 72 hou one of the within 72 hou one one. Ithan "natural one of the Medical E.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo d)	orking		16b. Kind of Business/Industry Household		
lar yianiu Zik	Be .	17. Father's Name ( <i>First, Middle, La</i>	eorge		1	TOTHERINAKET	18. Mother's Na	ame (First, Middle	e, Maiden	Surname)	<u>u</u>	
and 2 should be eath and Mental n 27 is marked of traumatic even	0	19a. Informant's Name/Relationship Sandy Napier				ng Address (Street		Rural Route Numi		Town, State, 2	Zip Code)	
partitione, interpretation of the partition of Health and Important: If item 27 is nany injury or other traunone.	2	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	Place of Dispo cemetery, cre	osition (Name of matory or other pla Veterans	ce) No	/. 01 2007	20c. Lo	cation - City or	Town, State	
Darti permit. Departir Importa any inju		21. Signature of Funeral Service Lie	Stal	King	22	2. Name and Addre	ess of Facility	Stalling	s Fun	eral Ho	ome, P.A.	
Physician		23a. Part V. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on a	caused the dea	Do not en	ter the mode of dyi			arrest,		Approximate Interval Between Onset and Death	
/Medical Examiner		resulting in death)		or as a consection of the cons	N	Arter	in E	sisens	و			
cate be executed physician and the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):											
	Ĭ								2	23d. Date of de Month	livery Day Year	
w requires that been signed by should be deta	ַ מ	Part II. Other significant condition	s contributing to d	leath but not res	sulting in the u	nderlying cause gi	ven in Part I.			se contribute to	o the cause of death?	
vital neco sician: The law rec s certificate has bee lirector, page 2 sho.	Completed							24a. Wa aut per 1□ Yes	s an opsy formed? 2 <b>10</b> No	prior to	utopsy findings available completion of cause of	
Physician: r this certifice ral director, 1	e e	25. Was case referred to medical examiner?	Hospital:	Innationt Of	E D/Outnotio	ot action of	ner:	eath (Check only	оле)			
2 g in the later l	1   Inpatient 2   R/Outpatient 3   DOA   Other: 4   Nursing Ho							28d. Describe			ecify)	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral preserved.	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad Zoe. Flaci	e of injury - At h ling, etc. <i>(Speci</i>	nome, farm, st	reet, factory, office			(Street an own, State		lural Route Number,	
the Hospi iin 24 hour the Funer ppletely fill	edical	29a. Certifier (Check only one)  Certifying  Certifying  Certifying	xaminer: On the I	e best of my kn casis of examin nner stated.	owledge, deat ation and/or ir	th occurred at the to nvestigation, in my	opinion, death or	ce, and due to the curred at the time	e cause(s) e, date and	and manner a d place, and du	s stated. e to the cause(s)	
To To Con	Σ	29b. Signature and title of certifier		MD		29c. Licen	se number		29d. Dat	te signed (Mon	th, Day, Year)	
6		30. Name and address of person w	ho completed cau	se of death (Ite		Print)		0. \		0	ie MD21061	
Stat Registra	е	31. Date filed (Month, Day, Year)	32	Registrar's Sign		DAKW	30C	KONG	6lev	1 DOLV	he mission	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #20b Per State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician DEBORAH** COHEN October 26, 2007 8:07pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore Towson 9. Birthplace (State or Foreign Country) If Under 1 Year Months Days If Under 24 Hrs.
Hours Min. Date of Birth Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 X F 06/30/1951 56 Director 218-60-5466 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21208 1332 CHURCH HILL DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 🛣 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) and 2 should be filed with ealth and Mental Hygiene. HEALTH CARE COUNSELOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FARLEY COHEN, SR MARGORIE **JOSEPH** ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any Injury or other tran-800 RANGEVIEW DRIVE, LITTLETON, CO JOSEPH COHEN / BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 11/01/2007 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP. 11/02/2007 TOWSON, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS. . INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Ventricular /Medical Due to (or as a consequence of): Examiner athenusc sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) as been signed by the 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 2 0 24a. Was an autopsy performed? Yes 20 No page certificate Attending Physician: funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ပ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Hospital or Attenct within 24 hours after death To the Funeral Director... filled in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30, Name and address of perso, who completed cause of death (Item 23a) (Type, Print) 5 35

Registrar DHMH 17 Rev 1/2001

State

Gosneli

31. Date filed (Month, Day, Year)

har

32. Registrar's Signature

State Registrar

DHMH 17 Nev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division or Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8186

of certifier

MILLES

29b. Signature and

31. Date filed (Month, Day, Year)

CANY

32 Registrar's Signature

Rown

29d. Date signed (Month, Day, Year)

21075

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Helen M. Deshaw 4:17 AM October 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Citizens Nursing Home Havre De Grace Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 29, 1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F 86 404-16-5527 Yrs. Director Kentűcky Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits ural", or items 23a or 28a-f sl Examiner must be notifled MD Harford Bel Air 1 ☐ Yes 🌂 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 951 Richwood Road Apt. B 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Evaminar l ∏Yes **X**∏ No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. ρ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roscoe Holder ဥ Lela Turpin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Paxton-son 3318 Woodspring Drive-Abingdon, MD 21009 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State EVANS FUNERAL CHAPEL AND 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Forest Hill Maryland 4 ☐ Donation 5 ☐ Other (Specify) CREMATION SER. BEL AIR 10/29/07 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 3 Newport Drive EVANS FUNERAL CHAPEL 3 Newport Drive AND CREMATION SERVICES Forest Hill,MD 21050 LME Foods endiae 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Disease Immediate Cause (Final disease or condition resulting in death) **Physician** orunan 5 yrs /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-transi Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1∐ Yes 2 or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 versing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No ပို Division or After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatule and title of certifier Whom

State Registrar

Ø

Vital Records, P.O. Box 68760,

Deshaw,

DOME.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

3 1 2007 D32609

Milhani MD 1106 Revolution St. Haure De Grace

10/27/0

07-08408 Maggie Dukes Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death Physiciant Control (1997)  Control (1997)	aggie Dukes		State		nd / Depa	rtment of He	aith and		Hygiene	20	07	3489
And Control Part Agency (1996) and the property of the propert	Physicia			ist)		inicate of Dec	<del></del>		2. Date of Death		3. Time	0 100
Sold West Startings Street    Sold Secular Number   Sold Start   Sold			MAGGIE	_	LEE	Do	IKE	S	Month Cotober 29,	Day Year , 2007	025	5 hrs
Total Control					mber)		•	ocation of De	eath	4c. County of Dea	ath	
Library   Libr	Europel				7 Age (in vrs. la			If I Inder 24	Hrs 8 Date of Birth	(MM/DD/YYYY) 9. I	Birthplace (	State or
The State   10.5 Cortex   10.5 Color   10.5					/ Age (III yis. id	7 A Mo				For	eign	1001111
3 3 Workerd 4 Debraced New Control of the Control o			712 2120	INI ZZIF		/ / 115.	i		NOV. O	8,1706	2, y	IKGINIH
3 3 Workerd 4 Debraced New Control of the Control o	' any		10a. State 10b. County		10c. City,	Town or Location	· · · ·					· ·
3 3 Workerd 4 Debraced New Control of the Control o	land f show	ō	MARYLAND N	IA		<u> </u>	SAL	TIME	ORE C	171/		res 2 No
3 3 Workerd 4 Debraced New Control of the Control o	Mary r 28a- ed at	irec	10e. St/eet and Number			10f.	Zip Code		100	g. Citizen of What Co	ountry?	
3 3 Workerd 4 Debraced New Control of the Control o	ith the 23a o	al D	36 / / W. 5	AKAT	OGA C	57.	odopt of High	$\frac{2}{2}$	(Specify Ves or No-	114 Page - Am	A India	an Black
3 3 Workerd 4 Debraced New Control of the Control o	eath w items ust be	ner		Armed Fo	orces?							iii, biack,
The state of the significant conditions  The state of the significant conditio	ifter de		3 Widowed 4 Divorce			1 Yes	2X No	specify:		Specify:	LAC	K
The state of the significant conditions  The state of the significant conditio	nours a	q pe	15. Decedent's Education (Specify	only highest grad	te completed)					16b. Kind of Busines	ss/Industry	
The state of the significant conditions  The state of the significant conditio	36 in 72 h han "r lical E	plet	Elementary/Secondary (0-12)	College (1	-4 or 5+)	B	4.0	1110	. ^	0.00		nuroul
The state of the significant conditions  The state of the significant conditio	-00, d with giene giene ther the	no:	17. Father's Name (First, Middle, Las	st)			HR 1	8.Mother's Na	ame (First, Middle, Ma	aiden Sumame)	2 //	EVERN
22. Signature of Funetile Service Licenses  23. Signature of Funetile Service Licenses  24. Signature of Funetile Service Licenses  25. Signature of Funetile Service Licenses  26. Signature of Funetile Service Licenses  27. Signature of Funetile Service Licenses  28. Part I. License the deades. or complications that caused the death. Don't derive the mode of dying, such as cardiac or respiratory affect, shock, or heart. Approximate Interval Between Interval Districts  28. Part I. License the deades. or complications that caused the death on or enter the mode of dying, such as cardiac or respiratory affect, shock, or heart. Approximate Interval Between Interval Districts  28. Part I. License the deades. or complications that caused the death of the cause or consideration of the cause of the children of the cause or considerate or considerate or considerate or considerate or cause. Enter Underlying Cause or rays maximized events resulting in death. License or part maximized events resulting in death. License or part maximized events resulting in death. License or part maximized events resulting in death.  28. Figure 1. License the deaders or considerate or considerate or considerate or considerate or considerate or cause or resulting in the underlying cause given in Part I.  28. Districts of the cause of death or constitution to the cause of death or constitution to the cause of death. Part II. Under the cause of death or constitution to the cause of death.  29. No considerate or con	215 be filed ttal Hy ked o		FOWARA	,	1 F	MON		111	LIAN	RE	DMO	NE
22. Signature of Funetile Service Licenses  23. Signature of Funetile Service Licenses  24. Signature of Funetile Service Licenses  25. Signature of Funetile Service Licenses  26. Signature of Funetile Service Licenses  27. Signature of Funetile Service Licenses  28. Part I. License the deades. or complications that caused the death. Don't derive the mode of dying, such as cardiac or respiratory affect, shock, or heart. Approximate Interval Between Interval Districts  28. Part I. License the deades. or complications that caused the death on or enter the mode of dying, such as cardiac or respiratory affect, shock, or heart. Approximate Interval Between Interval Districts  28. Part I. License the deades. or complications that caused the death of the cause or consideration of the cause of the children of the cause or considerate or considerate or considerate or considerate or cause. Enter Underlying Cause or rays maximized events resulting in death. License or part maximized events resulting in death. License or part maximized events resulting in death. License or part maximized events resulting in death.  28. Figure 1. License the deaders or considerate or considerate or considerate or considerate or considerate or cause or resulting in the underlying cause given in Part I.  28. Districts of the cause of death or constitution to the cause of death or constitution to the cause of death. Part II. Under the cause of death or constitution to the cause of death.  29. No considerate or con	21 hould I nd Mer is man		19a. Informant's Name/Relationship	(Type, Print )				and Number	or Rural Route Numb		ate, Zip Co	ie)
22. Signature of Funetile Service Licenses  23. Signature of Funetile Service Licenses  24. Signature of Funetile Service Licenses  25. Signature of Funetile Service Licenses  26. Signature of Funetile Service Licenses  27. Signature of Funetile Service Licenses  28. Part I. License the deades. or complications that caused the death. Don't derive the mode of dying, such as cardiac or respiratory affect, shock, or heart. Approximate Interval Between Interval Districts  28. Part I. License the deades. or complications that caused the death on or enter the mode of dying, such as cardiac or respiratory affect, shock, or heart. Approximate Interval Between Interval Districts  28. Part I. License the deades. or complications that caused the death of the cause or consideration of the cause of the children of the cause or considerate or considerate or considerate or considerate or cause. Enter Underlying Cause or rays maximized events resulting in death. License or part maximized events resulting in death. License or part maximized events resulting in death. License or part maximized events resulting in death.  28. Figure 1. License the deaders or considerate or considerate or considerate or considerate or considerate or cause or resulting in the underlying cause given in Part I.  28. Districts of the cause of death or constitution to the cause of death or constitution to the cause of death. Part II. Under the cause of death or constitution to the cause of death.  29. No considerate or con	MC 2 sland 2 sland 2 sland 2 sland 2 sland 27 raums	9		KES (H	USBAND	136/7					MD or Town S	2224
22. Signature of Funetile Service Licenses  23. Signature of Funetile Service Licenses  24. Signature of Funetile Service Licenses  25. Signature of Funetile Service Licenses  26. Signature of Funetile Service Licenses  27. Signature of Funetile Service Licenses  28. Part I. License the deades. or complications that caused the death. Don't derive the mode of dying, such as cardiac or respiratory affect, shock, or heart. Approximate Interval Between Interval Districts  28. Part I. License the deades. or complications that caused the death on or enter the mode of dying, such as cardiac or respiratory affect, shock, or heart. Approximate Interval Between Interval Districts  28. Part I. License the deades. or complications that caused the death of the cause or consideration of the cause of the children of the cause or considerate or considerate or considerate or considerate or cause. Enter Underlying Cause or rays maximized events resulting in death. License or part maximized events resulting in death. License or part maximized events resulting in death. License or part maximized events resulting in death.  28. Figure 1. License the deaders or considerate or considerate or considerate or considerate or considerate or cause or resulting in the underlying cause given in Part I.  28. Districts of the cause of death or constitution to the cause of death or constitution to the cause of death. Part II. Under the cause of death or constitution to the cause of death.  29. No considerate or con	Ore, ges la of He If ite			Removal fr				letery,	_			
Physician (Modical Xaminer)  23a. Part L. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory affect, shock, or heart. Approximate interval Between Onset and Death (Death of Death ti. Pag rtment rtant: y or o				NE	W CATHI	EDRA	//	1-02-01	BALTIM	ORE	MD	
Figure List only one cause on each line.  ### Add and Neck Injuries    Condition resulting in death   Condition resulting in the underlying cause given in Part I.   Condition resulting in the underlying cause given in Part I.   Condition resulting in the underlying cause given in Part I.   Condition resulting in the underlying cause given in Part I.   Condition resulting in the underlying cause given in Part I.   Condition resulting in the underlying cause given in Part I.   Condition resulting in the underlying cause given in Part I.   Condition resulting in the underlying cause given in Part I.   Condition resulting in the underlying cause given in Part I.   Condition resulting in the underlying cause given in Part I.   Condition resulting in the underlying cause given in Part I.   Condition resulting in the underlying cause given in Part I.   Condition	Bal permi Depa Impo		21. Signature of Fulleral Service Lice	1.//	Minn	JO 3	FF PIH	Est &	BROWN	BAITA K	SKAL	10116
mmediate Cause (Final disease a consequence of):    Seaponial Plant   Seaponial Plan	Physician				aused the death.	Do not enter the mo	de of dying,	such as cardi	ac or respiratory arres	st, shock, or heart		
To Control resulting in death)  Sequentially list conditions  Sequentially list conditions  Sequentially list conditions  If any, leading to immediate a consequence of):  Due to (or as a consequence of):  Due t		W H			Neck Injuries						Detw	
Due to (or as a consequence of):    Total Part   Total Pa	Adminier		or condition resulting in death)	Due to (or as a	consequence of	f):						
UNPENDED   AMENDED   AMENDED   AMENDED   FEMALE:   23c. If yes, outcome of pregnancy   23d. Date of delivery   Month   Day   Year   Propagation   1   Use birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Year   Propagation   1   Yes 2   No 3   District   1   Yes 2   No 3   Probably 4   Unknown   Part II. Other significant conditions   Contributing to death but not resulting in the underlying cause given in Part I.   23c. If yes, outcome of pregnancy   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?		er		b Due to (or as a	consequence of	f):						
UNPENDED   AMENDED   AMENDED   AMENDED   FEMALE:   23c. If yes, outcome of pregnancy   23d. Date of delivery   Month   Day   Year   Propagation   1   Use birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Year   Propagation   1   Yes 2   No 3   District   1   Yes 2   No 3   Probably 4   Unknown   Part II. Other significant conditions   Contributing to death but not resulting in the underlying cause given in Part I.   23c. If yes, outcome of pregnancy   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24s. Was an autopsy performed?		ımi	(Disease or injury that initiated	C. Duranta (an an a		£\.						
FFEMALE: 230. Was case referred to medical examiner?   1   1   1   1   1   1   1   1   1	A nited		events resulting in death) Last	d.	consequence o	1).						
FFEMALE: 230. Was case referred to medical examiner?   1   1   1   1   1   1   1   1   1	e exec	Jical	UNPENDED	AMENDED								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions	760, cate by physic the but	/Mec				nancy						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions	certification	cian				noth		Ectopic pre	egnancy	Month	Day	Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions   Part II. Other significant   Part II. Other significant conditions   Part II. Other	Box death	ysi	1 Yes 2 V No 9 Unknow	wn 9 Unkno	own	o Linei (						
Solve the proof of	bat the ed by tetache		Part II. Other significant conditions	s contributing to	o death but not re	esulting in the underl	ying cause g	iven in Part I.				
The proof of the p	— s .50 e								- 1			
The proof of the p	aw rec as bee	ple							autops	sy prior	to completi	
25. Was case referred to medical examiner?  1	Rec The ficate ficate	Con							1 <b>✓</b> Yes 2			2 No
29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature	ital sician: s certi irector		examiner?	Hospital:	Innatient 2	ER/Outpatient 3		Other:		Residence 6 🗸 O	ther: Scene	
29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature	of V g Phy fter thi	-		28a, Date	of Injury				28d. Describe h			
29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature	lon lendin eath. or: A the fur	tion	pending	0-4.00			1_ Y	res 2 🗸 No	Subject fell			
29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature	ivisi or Att after d Direct	tifica	3 Suicide 6 Could no	ot be 28e. Plac			tory, office b	uilding, etc.			Rural Rou	te Number, City
29d. Date Signature and title of certifier  O.C.M.E.  October 29, 2007  30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Di spital hours : neral / filled		4 Homicide	(Open,)					3617 West Sa	ratoga Street, Bal		)
29d. Date Signature and title of certifier  O.C.M.E.  October 29, 2007  30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	the Ho nin 24 the Fu upletely	ical	(Check only   Certifying Phys									e(s)
30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	To To Com	Med		and manner s	stated.				•			
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			Pot . ().	00	D000	8-110	O.C.1	M.E.		October 29, 2	007	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	2		30. Name and address of person wh	no completed cau	se of death (Item			·				
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 0CT 3 1 2007							1 Penn St	reet, Baltir	more, MD 21201			
			31. Date filed (Month, Day, Year) 0CT 3 1 2			Acade						

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year OCTOBER 29, 2007 **Physician** MARY MARGARET DUNNIGAN 8:45 a<sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** GILCHRIST CENTER FOR HOSPICE BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 14,1946 MARYLAND 61 218-48-4482 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County XXYes 2 ☐ No Director MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 914 S. BOULDIN STREET 21224 U.S.A. death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABORER JESCO BOX CO. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRANCIS BERNARD DUNNIGAN TERESA ROSE HELGERT ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21009 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health a
Important: If item 27 is
any Injury or other trau
once. 709 SCOTTISH ISLE DR., ABINGDON, MD. EVELYN DUNNIGAN/SISTER-IN-LAW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State OAK LAWN CEMETERY 11/2/07 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME 700 s. CONKLING STREET, BALTO., MD. 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 5 Other (specify) 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ndrome 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 2 No page 2 s or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 1 Yes 2 No 6 Other (Specify) ၉ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: , 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 31. Date filed (Month)

BMC 6701 Day, Year) OCT 3 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32 Registrar's Signature

**ORIGINAL** 

29c. License number

29d. Date signed (Month, Day, Year) October 29, 2002

Balto Md 2:20x

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	aryland		artment of F rtificate of		Mental Hy	giene Reg. No.2		34901
<i>V</i>	- Physici	an	1. Decedent's Name (First, Middle, La	st)			-		2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic	cal	4a. Facility Name (If not institution, giv	Lois Laver	ne Da	rling	4h City Town o	r Location of Deat		er 24,	2007 ounty of Death	9:10PM M
	Examir	ner	Shady Grove Ad		spita	1	7 /	ockville		40.00		gomery
77	Funeral		5. Social Security Number 6. S			st birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi	rth ay, Year)		place (State or Foreign intry)
16- 12	Director	9	414-26-7799 Usual Residence of Decedent	TE W ZAT	81	Yrs.			April 1	0,192	6 T	ennessee
	yland iow		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	e Mar a-fsh tified	cto	Maryland Mont	gomery			Ro	ckville				1 X Yes 2 □ No
	or 28 be no	Director	10e. Street and Number				10f. Zip Code			10g. Citizer	n of What Cou	untry?
	eath v	eral		Street #2		13 1	Was Decedent of H	20850	Specify Ves or N	0- 14	United	States
"	r Iter d	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 1 1			Vas Decedent of H f Yes, specify Cuba		to Rican, etc.)	J. 14.	Black, White	
21215-0036	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	Completed by	3 K Widowed 4 □ Divorced	If Yes, Give Year or Dates:			I∐Yes 2∭X No	Specify:		Sp	pecify:	White
5-0	"natu	letec	15. Decedent's E (Specify only highest gra	ducation ade completed)		(Give	lent's Usual Occup kind of work done OO NOT use retired	during most of wo	orking	16b. Kind	of Business/Ir	ndustry
12	withir ene. than he Me	шc	Elementary/Secondary (0-12)	College (1-4or 5	+)	ine. L	Secre	,		Unite	dState	sGovernment
d 2	other other	BeC	17. Father's Name (First, Middle, Last	")		** **	50010		me (First, Middle			
ylar	Menta Menta arked aric e	To E	William	States Ro	binso	n			Jenni	e Boat	twright	
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (				g Address (Street					,
آو. –	Healt Healt tem 2 other		Lewis E. Darlin 20a. Method of Disposition	g, 111/ So:	20b. Pla	ace of Dispos	sition (Name of	i	Road, Mo		.a, Mary ition - City or T	1and 21770 Town, State
m 0	Pages ent of nt: If i		1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia			Mont	natory or other place gomery rium Inc.	0c	tober 2007	Roth	sheer	Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra	1	21. Signature of Foneral Service Lice	nsee	, 01	22	Name and Addre	ss of Facility Ro	bert A.	Pumph	rey Fu	neral Nome/ Avenue
	80 E 9 9		(kya)		M0033	5	Rockvill	e, Maryl	land 208	50-280	5501111	
			23a. Part1. Enter the disease or correshock, or heart failure. List only immediate Cause (Final	one cause on each lir	the death.	Do not ente	er the mode of dyir	ig, such as cardia	ic or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a. Aspira Due to (or as			onia				_	4 Days
	Examiner		Convertible the conditions	h								
	W #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):						
	al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):					-	
68760,	tificate be executed by physician and as the burial-transit	edical E		▲d								
89 >	ertifica ing ph e as th	Medi	IF FEMALE:									
Вох	eath certifi attending for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3□	Ectopic pregnancy Other (specify)	/		230	<li>d. Date of delive Month</li>	very Day Year
0	that the de ned by the a detached i	Physician/M	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	9☐Unknown	time or dea	au	Other (specify)					
S, P.	The law requires that the death cort to has been signed by the attending tage 2 should be detached for use	by P	Part II. Other significant conditions	contributing to death bu	ut not result	ting in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
ord	require een si	ted							1	Yes 2X	No 3□Pro	obably 4 ☐Unknown
Records,	has b	Completed							24a. Was		24b. Were aut prior to co death?	topsy findings available ompletion of cause of
			25. Was case referred to medical					26 Place of Do	1□ Yes	2 <b>∏</b> No		2□ No
or Vital	> .00 0	To Be	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1   ☐ Inpatie	nt 2∐E	R/Outpatien	t 3 DOA Oth		Home 5 ☐ Res		 ⊒Other (Spec	ify)
n o			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry Year) 2	28b. Time of Injury	Wor	y at k?	28d. Describe			
Division	Attending r death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not b	e 28e Place of init	ırv - At hom	ne farm stre	M 1 □	Yes 2 ☐ No	28f Location	(Stroot and N	Number or Pu	ral Route Number,
Οį	al or A s after il Dire	Certification:	4 ☐ Homicide determined	building, etc	(Specify)	,			City or To	wn, State)	variber or riar	arrioute Number,
	To the Hospital or Attent within 24 hours after deat! To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 A Certifying Pl (Check only one) 2 Medical Example 1	nysician: To the best of miner: On the basis of and manner sta	examination	fedge, death on and/or inv	occurred at the til vestigation, in my	me, date and plac opinion, death occ	e, and due to the curred at the time	cause(s) ar , date and pl	nd manner as lace, and due	stated. to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date s	signed (Month	, Day, Year)
			* Blayant	cum.				D0064502	2	0ct	ober 2	5, 2007
-	10		30. Name and address of person who					rive D-	12 1 1 -			
	Sta	ite	Brian Carpenter 31. Date filed (Month, Day, Year)	, M.D. 990			enter dr	ive, Koo	ckville,	maryl	Land 20	טכטי
	Registr	_	UGI 3 1 2007	8 80%	2. 1	6,2846						

DHMH 17 Rev 1/2001

		1 - State Registrar			Certifica	ate of i	Death		Reg. No	2001	34907
Physic	rian	1. Decedent's Name (First, Middle, La	st)					2. Date of D Month	Da	ay Year	3. Time of Death
/Med			<u>ne Lucille</u>	Egan				Oct. 2		2007	12:49 P <sup>M</sup>
Exam	iner	4a. Facility Name (If not institution, giv			4b. C	ty, Town, or	Location of Dea	ath	40	c. County of Death	
		7117 Bellona A		e (In yrs. last birt	thday) If Un	der 1 Year	Towson	rs. 8. Date of B	irth	0 Rieth	imore place (State or Foreign
Funera Directo			I M 2 1 F	. ,	Yrs. Montl		Hours Min		a <i>y, Yeai</i>	Cou	sylvania
land ow		10a. State 10b. County		10c. City, Towr	or Location						10d. Inside City Limits
Mary -f sh	ţ	Maryland Baltimo	re	Balt	imore						1 □ Yes 2½ ŠNo
Dattilliore, IMarylating Z.I.Z.13-0030  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at mone.	Il Director	10e. Street and Number 7117 Bellona A				Zip Code			Un	itizen of What Cou ited Sta America	
death ms 2	Funeral	11. Marital Status	12. Was Decedent E	ever in U.S.	13. Was De	cedent of H	lispanic Origin?	(Specify Yes or Nerto Rican, etc.)		14. Race - Ameri	
OUSO hours after ural", or Ite	þ	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	lo		No XX No	Specify:	eno Alcan, etc.)		Black, White	ite
in 72 ho	Completed	15. Decedent's E (Specify only highest gra	ade completed)	1 1	Decedent's U (Give kind of life. DO NO	sual Occup work done of use retired	ation during most of w	vorking	16b. I	Kind of Business/Ir	ndustry
with giene. r than	E	Elementary/Secondary (0-12)	4 College (1-4or 5		Iomemak	er				Residenc	е
land he filed lental Hyg ked othe ic event,	BeC	17. Father's Name (First, Middle, Last	)				18. Mother's N	ame (First, Middle	e, Maide	n Surname)	
Venta Wenta	10E	Howard A. Lum	op				Luc	cille E.	Dun	lap	
Mary d 2 sho th and I		19a. Informant's Name/Relationship (			_					or Town, State, Zi	
and and m 27		Cynthia Egan / da	aughter							Maryland	
DallIIIIOTE Demit. Pages 1 Department of H mportant: If ite any Injury or ott		20a. Method of Disposition  1 ☐ Burial 2 ☑Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia		20b. Place of cemeter Evans Chapel	funera Bel	vame of Drother plac 1 Air	ce) OC 28	tober , 2007		ocation - City or T	own, State l, Maryland
permit. Departi		21. Signature of Juneral Service Lice	nsee		Peace 2325	and Addre ful A York	ss of Facility 1 ternat: Road T	ives Fun	eral Mar	&Cremat	ion Ctr., E
610		3a. P. rt1. Enter the disease, or com shock, or heart failure. List only	p ations that caused	the death. Do r	not enter the n	node of dyir	ng, such as card	iac or respiratory	arrest,	·	Approximate Interval Between Onset and Death
flicate be executed lifeting and bulby sician and street the burial-transit	Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	a consequence of	of):						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of the composition of the com	2 Fetal death	3 □Ectopi 5 □ Other		/			23d. Date of deliving Month	/ery Day Year
s that ined by	by Ph	Part II. Other significant conditions	contributing to death bu	ut not resulting in	the underlyin	g cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
w requires to been signer should be								- 1	] Yes	2 No 3 Pro	bably 4 Unknown
The law rate has be bage 2 sh	Completed							24a. Wa auto per 1⊟ Yes	opsy formed?	death?	opsy findings available ompletion of cause of
ilan: artifica ctor, p	Be C	25. Was case referred to medical examiner?					26. Place of D	eath (Check only			
Physic this ce	To	1 Yes 2 No	Hospital: 1 ☐ Inpatie			DOA Oth	4 LI Nursing	Home 5 Res	sidence	6 □Other (Spec	ify)
ding P th. After t funera		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Yea <i>r)</i> 28b. 1	Time of njury	28c. Injur Wor		28d. Describe	how inj	ury occurred	
r Attend er death. rector: /	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined		iry - At home, fa	rm, street, fac		Yes 2 □ No	28f. Location City or To		and Number or Rui	ral Route Number,
o the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, it	edical Cer		nysician: To the best of miner: On the basis of	of my knowledge examination an	, death occur	red at the tir					
To the within ?	Med	29b. Signature and title of certifier	and manner sta			29c. Licens				ate signed (Month	
	4	20 Name and address of second	" WEPUT!	outh /Itom 035) /	Tuno Brist	1110	1991		$\mathcal{O}_{\mathcal{C}}$	Joben 2	1,200/
10		30. Name and address of person who	S M M	6 T	rumbl	e H:	( CTI	utheris	:lle	Md 2	72007
s	tate	31. Date filed (Morth, Day, Year)	32. Registra	ar's Signature				. ,			

State Registrar

V	
Box 68760,	
P.O.	
Records,	
Vital	
ō	
Division	

				Please T				delible Ink.		_		.egible.		
			For State Registrar		State of Ma	aryland		artment of F ertificate of		d Mental Hy	giene Reg. No.	דחחק	31.91	13
		-1	Registrar     Decedent's Name (First	st, Middle, Last)				Timoato or	Douin	2. Date of D		Year	3. Time of Dea	
	Physicia /Medic			Anette 1				T		10	26	2007		Рм
	Examin	er	4a. Facility Name (If not i	4 1	1 4	tal		4b. City, Town, o	t i ~		40.0	County of Death		
-	Funeral		5. Social Security Number	er 6. Se	. 4- 1	e (In yrs. las		) If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bi	av. Year)	_ Cou	place (State or For	_
	Director		217-84-3710 Usual Residence of Dece		IN SE	40	Yrs.			08/15/	1967	Balt.	, Maryla	nd
	iryland show	_		. County		10c. City,							10d. Inside City Lin 1 ☐ Yes 2	
	the Ma 28a-f s notified	Director	Maryland 1	Baltimo:	re	Ba.	ltimo	10f. Zip Code			10g. Çitiz	en of What Cou		Y
	th with 23a or ist be		3416 North		ive			2123	34			en of What Col ed Stat merica	.es	
	er deal	Funeral	11. Marital Status	OCT Marriad	12. Was Decedent I Armed Forces?	Ever in U.S.	13	. Was Decedent of H If Yes, specify Cub	lispanic Origin an, Mexican, F	? (Specify Yes or N Puerto Rican, etc.)	0- 1	<ol> <li>Race - Amer Black, White</li> </ol>		
036	be filed within 72 hours after death with the Maryland Hydiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1XXNever Married 3 3 □ Widowed 4 □ I		1 ☐ Yes 2 2 2 1 If Yes, Give Year or Dates:	40		1 ☐ Yes 🏚 No	Specify:			Specify:	lack	
Maryland 21215-0036	"natur	Completed	15. l (Specify or	Decedent's Edu nly highest grad	cation e co <i>mpleted)</i>		16a. Dec	edent's Usual Occup e kind of work done DO NOT use retire	during most of	f working	16b. Kin	d of Business/I	ndustry	
212	yiene.	dwo	Elementary/Secondary	y (0-12) 12	College (1-4or 5	i+)		t secreta			Но	spital		
pu	uld be filed v fental Hygid rked other tic event, th	Be	17. Father's Name (First,							Name (First, Middle		Surname)		
ıryla	2 should be and Mental is marked aumatic ev	욘	William Woo				19b. Mai	ling Address (Street		erine Jon or Rural Route Num		Town, State, Z	ip Code)	
, Ma	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Denise Burr	is/ sis	ter			6 Northwa			<del></del>			
ore	ages 1 nt of H : If iter		20a. Method of Disposition 1 Burial 2 Arcre	emation 3 🗆 F	lemoval from State	20b. Pla ce Evai	ce of Disp netery, cr 1S_ £\	position (Name of ematory or other pla Ineral Bel Air	ce) N	ovember		eation - City or		_ ,
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		4 □ Donation 5 □  21. Signature of Funeral		ee /	Cha	pel-	Bel Air 32 Name and Addig	T :	, 2007 tives Fun			1, Maryla	
ä	permi Depar Impor any Ir		Mofeto.	KX,	1			eaceful <sup>add</sup> 2325 York				yland 2		
			234. Part . Enter the dis shock, or heart fail Immediate Cause (Final	lure. List only o	ne cause on each lir	ne.				rdiac or respiratory	arrest,		Approximate Interval Between Onset and Deat	
À	Physician /Medical		disease or condition resulting in death)		Due to (or as	a conseque	nce of):	sculities	age				3 day	2
Н	Examiner	_	Sequentially list condition	ons,	Due to (or as	a conseque	vice of):	salitis					3 mont	hs
V	d d ansit	Examiner	Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury that initiated events	g y	2	a oonooqu	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
90,	icate be executed physician and s the burial-transit	_	resulting in death) Last		Due to (or as	a conseque	nce of):							
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	edica		-	i					-				
Вох	leath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent preg in the past 12 mon	gnant	3c. If yes, outcome 1□Live birth	2 Fetal	death 3	□Ectopic pregnanc	;y		2	3d. Date of deli	very Day Year	,
P.O. E	s that the desined by the at	ıysici	1 ☐ Yes 2 ☐ No 9 💢 Unknown		4□Pregnant at 9□Unknown	time of dea	ath 5	Other (specify) _						
	es that igned by be deta	by Ph	Part II. Other significan	A			_						the cause of death	
ord	w require been si should t		pulmonar									(No 3□Pr		
Records,	: The law cate has t page 2 s	Completed	Heart Foi	ilure,	lupus er	ofthe	mas	20SUS,S	clecade	per	opsy formed?	prior to death?	topsy findings avai completion of cause 2X No	e of
Vital	sician: Th certificate rector, pag	Be C	25. Was case referred to examiner?							l□ Yes f Death <i>(Check only</i>		I To res	ZANO	
or \	Phys this ral dir	ပ္	1 ☐ Yes 2 No 27. Manner of Death		lnpatie 28a. Date of Inju		R/Outpati 28b. Time	ent oll box		ing Home 5 ☐ Re			cify)	
ion	Attending I r death. ector: After by the funer	ation	1 Natural 5   2 ☐ Accident	☐ Pending investigation	(Month, Da		Injury		ork? ]Yes 2∐No					
Division	To the Hospital or Attend within 24 hours after death. To the Funeral Director: , completely filled in by the f	Certification:	3 ☐ Suicide 6   4 ☐ Homicide	Could not be determined	28e. Place of inj building, et	ury - At hon c. <i>(Specify)</i>	ne, farm, s	street, factory, office			(Street and own, State)		ıral Route Number,	,
	Hospital or 24 hours afte Funeral Dir tely filled in							ath occurred at the t						
	To the H within 24 To the Fl complete	Medical	one) 29b. Signature and title		and manner st		on and/or	29c. Licen	se number		29d. Date	e signed (Mont	h, Day, Year)	
	F 3 F 8		)	Ka	M.D.			RE	5-00	00	10-	-26-	2007	
	3		30. Name and address of AMIR KA		ompleted cause of d	leath (Item	23a) (Typ	e, Print) en Blvd	Rn	Himan	Mr	2123	9	
8	Sta	ate	31. Date filed (Month, D						100	C I ITTOTE	٠.٢	(		
	Regist	rar	UUI	0 1 ZUL	outly win	and and had a to	and the same of th							

State of Maryland / Department of Health and Mental Hygiene Registrer

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** EVANS MARGARET

4a. Facility Name (If not institution, give street and number) 12:551 10 30 -07 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ellicott City Health & Rehab Center Ellicott City Howard 5. Social Security N71463 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Jan. 05 Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F Months Hours Min 90 Yrs Jäň. Director Usual Residence of Decedent with the Maryland it. Pages 1 and 2 should be filed within 72 hours after death with the Manylan itment of Health and Mentat Hyglene.
-rient: If item 27 is marked other then "natural", or Items 23a or 28a-f show injury or other treumatic event, It a Manifeal Examiliar mast be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Carroll Westminster Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 507 High Acre Drive 21157 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify. þ 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 4. Homemaker Household 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Frank Cameron Gilbert Madeline Isabel 2 Be11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Ingraham (daughter) 9 Oak Shadows Court, Catonsville, MD 21228 Nov. Date 03 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Chenango Valley Crem. 2007 Earlville. New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atherosclerotic Cardovaralar Dipeare Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit requires that the death certificate be executed Decabitus Due to (or as a consequence of). P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b firector, page 2 s 24a Was an 1 Yes 2 NO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 🗌 Yes Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of of or Attending Patter death. 28d. Describe how injury occurred Natural 5 Pending investigation after death.

Director: Aff 2 Accident 1 Yes 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide the Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30641 Ochber 30 2007 h Name and address of person who completed cause of death (Item 23a) (Type, Print) 201-109 Back River Neck Road Baltonia Mayland 2121 Hameth Saba palhe 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar 9 2007

07-08330 Doris Flemming

M

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 34905

riemming		- For State	Cer	tificate	of Deat	h				g. No		Time of Death
hysicia	ın/	Registrar 1. Decedent's Name (First, Middle,Las							Date of Death Month	Day Ye	ear 3.	1320 hrs
Examir	ner	Doris Weems Flemi							October 26	4c. County	of Death	
		4a. Facility Name (if not institution, given			4b. City,	Fown, or Lo	ocation of	Death		4c. County	n/a	
		116 W. 30th Street Aparty	nent 1234				Lieu II.	0411	0. Date of Pirt	b/MM/DD/VVV		lace (State or
<b>Funeral</b>		5. Social Security Number 6. S	ex 7. Age (In yrs. Ia		Month	er 1 Year ns Days	If Under Hours	Min.	8. Date of Bitt	11(1010/100/11)	Foreign]	Prankfort,
Director	- 1	212-26-8331	м 2 <sup>X</sup> F 93	·	Yrs.				Aug.19	7,1914	Coun	try) Kentucky
	į	Usual Residence of Decedent		Town or Lo								0d. Inside City Limits
/ amy		10a. State 10b. County										1 X Yes 2 No
show	5	Maryland N/A	A Ba	ıltimo						Og. Citizen of V	Mhat Count	ν?
ne Maryland or 28a-f show fred at once.	Director	10e. Street and Number			10f. Zi	o Code			''	ug. Citizen or v	VIIat Godin	,
a or		116 W. University					1210			<u>Jnited</u>		
with th	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13	. Was Deced	ent of Hisp	anic Orig Mexican.	in? ( Spec Puerto R	cify Yes or No ican, etc.)		ce - America nite, etc.	an Indian, Black,
r iten	E I	1 Never Married 2 Marrie	1 Yes 2 X No							0	Wh:	ite
offer of line, o	by F		d If Yes, Give Year or Dates:		Yes			: d 6	al dono	Specify 16b. Kind of		dustry
atura cami	o p	15. Decedent's Education (Specify		16a. Dec	edent's Usua ng most of w	l Occupation	on (Give i DO NOT	use retire	d)	IOD. KING OF	Dusinossiin	
72 h	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+) n/a		Book	Keep	or				Bank:	ina
O3(ithin ar than the	ď			l	DOOK			s Name (	First Middle.	Maiden Surnar		1119
1 othe		17. Father's Name (First, Middle, Las							ginia		,	
121 l be fi ental arked	Be	Richard P. Weems		I 10b M	lailing Addre	s (Street	and Num	ber or Ru	ral Route Nur	mber, City or T	own, State,	Zip Code)
D 2	To	19a. Informant's Name/Relationship Mr. Jeffrey Jol			7 E. B:					Marylan		014
nd 2 salth a		20a. Method of Disposition		Place of D	isposition (N	ame of cen			Date	20c. Location	on - City or T	own, State
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or iten or other tranmatic event, the Medical Examiner must		1 Burial 2 X Cremation 3	Removal from State		or other plac unera		nel	Oct.	.31,	Fores	+ 1141°	l,Maryland
Pag Pag ment tant: or ot		4 Donation 5 Other Speci	ify:									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of Funeral Service Lic	ensee Jan h	_	Peace	Tul A	Iteri	hatiy	res Fur	neral&C	remat:	ion Ctr.,P.A 21093
		23á Part I. Enter the disease, or cor	//- /-	h. Do not e	nter the mod	e of dying,	such as	ardiac or	respiratory ar	rest, shock, or	heart	Approximate Interval
ysician ≀Medical		failure List only one cause on	each line.			, .						Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic Cardio		Disease							
		or condition resulting in adda.	b	01).								
	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of):								1
	l iE	cause. Enter Underlying Cause (Disease or injury that initiated	c	-A:								
/ Bait	Examiner	events resulting in death) Last	Due to (or as a consequence	OI).								
ffcate be executed g physician and s the burial - transit	<u></u>	UNPENDED	AMENDED DORME OF		/03 /03							
0, be en sician surial	Medical	UNPENDED	AMENDED, perME, g8	3/2, 10	)/3 <u>1/0/</u>	I'I' _				23d. Dat	te of delivery	/
876 ficate g phy s the	\ \{\bar{2}{5}}		1 Live birth	2	Fetal dea	ith 3	Ectop	ic pregna	ncy	Mon	th [	Day Year
Sox 687 death certific e attending   for use as the	sician	past 12 months?	4 Pregnant at time of		Other (S	pecify)						1
Boy dearth he attr d for	is	1 Yes 2 ✔ No 9 Unkno							Did Did	tobacco use c	contribute to	the cause of death?
O. at the	y Phy		ns contributing to death but no	t resulting i	n the underly	ing cause	given in F	art I.				bably 4 🗸 Unknown
, P.C ires that signed	2											utopsy findings available
cords, law requir has been s	Completed									opsy	prior to	completion of cause of
COI law law e has	1 2									formed?	death? 1 ✔ Y	es 2 No
Re: The	ع					26.Plac	e of Deat	h (Check	only one)			
ital iician s cert recto	ď	examiner?	Hospital: 1 Inpatient 2	ER/Out	patient 3	DOA	Other <sub>4</sub>	Nursir	ng Home 5	Residence	6 🗸 Othe	er: Scene
Phys er thi	F	27 Manner of Death	28a Date of Injury	28b. Ti	me of Injury	28c. Inj	ury at Wo	rk?	28d. Describ	e how injury o	ccurred	
iding h. h.	5	1 V Natural 5 Pendir	(Month, Day, Year)			1	Yes 2	No	1			
SiO Atter r deal ector by th	100	2 Accident Investi	28e Place of Injury - A	t home, fari	m, street, fac	tory, office	building,	etc.			lumber or R	ural Route Number, City
DIVI	Cortification.	3 Suicide 6 Could determ	not be						or Towr	1, State)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Directors. After this certificate has been signed by the attending physician and committees filled in white funeral director, page 2 should be detached for use as the burial - transit	2			ledge, deat	h occurred a	t the time,	date and	place, and	d due to the ca	ause(s) and ma	anner as sta	ited.
the H the F the F		(Check only one) 2 Medical Exam	iner:On the basis of examinatio	n and/or in	vestigation, i	n my opinio	on, death	occurred	at the time, da	ate and place,	and due to t	he cause(s)
To To To	Modical	29b. Signature and title of certifier	and manner stated.			29c. Licer				29d. Date	signed (M	onth, Day, Year)
		111. 1.	anell m			0.0	M.E.			Octobe	er 27, 200	07
d		30. Name and address of person v	who completed cause of death ()	tem 23a)								
D		30. Name and address of person values and Melissa Brassell, MD	Assistant Medical Exa	miner	111 Penr	Street,	Baltime	ore, MD	21201			
	 Stai		32 Registrar's Sign		A							
Reg		007004	2007 Margar	the s	Basele	<i>F</i>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34906 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Edna Furgio 10-29-2007 0808 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Hospital Bel Air Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-04-1924 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 🖸 F Director 219-20-9647 83 Kentucky Usual Residence of Decedent 10a. State 10c. City, Town or Location fshow 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notifled at Director 1 ☐ Yes 2 ☑ No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 100 J Hazelnut U.S.A.

14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2X Married "natural", or 1 ☐ Yes 2 🔀 No ģ 3 Widowed 4 Divorced White Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Factory Worker Industrial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bill Brown Laura Padson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adriano Furgio (Husband) 100 J Hazelnut Ct Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Highview Mem. Gar. 11-01-2007 Fallston, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each process. Approximate Interval Between Onset and Death is cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a Examiner 100 Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or 1) as the burial-tran attending physician Physician/Medical IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 mon 1 Yes 2 No Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown been signed by should be detact contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ H0 24a. Was an certificate has autopsy perform director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes / 2 ☑ No 1 Inpatient ER/Outpatient 3 🗆 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred the Hospital or Attending hin 24 hours after death. 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 30. Name and addre

Registrar

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34907 Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:02PM Louis Gilbert Greenwell 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Jan. 15 1 Glen Burnie Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 □ F 214-26-3869 1928 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show at 1 ☐ Yes 2 ☐ No the Medical Examiner must be notified Directo Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8274 Railroad Avenue 21122 USA "natural", or items 23a by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hyglene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me College (1-4or 5+) Mail Carrier USPS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Τ. Greenwell Elizabeth Α. Schipferling ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy L. Greenwell 8274 Railroad Avenue, Pasadena, MD 21122 (spouse) Date 31 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 2007 4 ☐ Donation 5 Other (Specify) Glen Burnie, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Stallings Funeral Home, P.A. <u>3111 Mountain Road. Pasadena. MD 21122</u> e, or complications that could be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause the chiline. 23a. Part1. Enter the dis \ se, shock, or heart failur. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardia **Physician** 2 hours /Medical Due to (or a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed Due to (or as a consequence of): Box 68760, physician Physician/Medical attending properties for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9□Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy page perform sate 2 No certifica or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA ို 1 ☐ Inpatient this funeral 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation (Month, Day Year) death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident Funeral Director: tely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 h 29c. License number 29d. Date signed (Month, Day, Year) BM8741527 10/28/2007 O. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 Oakwood ATNAKAR MUKHERTEE, MD GIEN Burnie, M

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

<b>2</b> , <u>–</u>		1 - For State Registrar  1. Decedent's Name (First, Midd)		n iviai yidi	•	artment of I		2. Date of D	Reg. No.	000 -	3 4 9 0 3. Time of Death
Physic /Medi		Barbara A	Anne Hende	rson				Month 10	Day 26	Year 2007	6:00 A.
Exami		4a. Facility Name (If not institution	-	mber)		4b. City, Town, o	or Location of D			County of Dea	
		Stella Maris 5. Social Security Number	Hospice 6. Sex	7. Age (In yrs.	last hirthday	Timon If Under 1 Year		Hrs. 8. Date of E		Baltimo	
Funeral Director		218-40-2180 Usual Residence of Decedent	1□M 2∏F	7.7.go (//, y/o.	65 Yrs.	Months Days		vin. (Month, L	Day, Year) 5/1942	2 Bal	thplace (State or Foreign ountry) t., Maryla
how	_	10a. State 10b. County			ty, Town or Lo						10d. Inside City Limit
28a-f s otiffe	ecto		imore		Perry						1 □ Yes 2√∑ N
a or 2	į	10e. Street and Number 4025 Baker La	ine			10f. Zip Code 2123	36		Unite	zen of What Co ed Stat	es
natural", or items 23a or 28a-f show dical Examiner must be notifiled at	Funeral Director	11. Marital Status		edent Ever in U	J.S. 13.	Was Decedent of H		? (Specify Yes or N		America 14. Race - Ame	erican Indian,
Department of Health and Mental Hygiene. Importants: If item 27 Is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 🖾 Divorced	ried 1 ☐ Yes	2∰No ve		1 ☐ Yes 2 ☐ No		uerto Hican, etc.)		Black, White	
'natur dical	Completed by	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of	working	16b. Kii	nd of Business	/Industry
than he Me	dmo	Elementary/Secondary (0-12)	College (	1-4or 5+)		<i>во пот use retire</i> al Transc			LIC	agaital	
l Hygi other ent, t	Be Co	17. Father's Name (First, Middle,			ricaro	ar iransc		Name (First, Middi		ospital Surname)	
Menta Irked Itic ev	To B	Howard Weld	on Mackle	У			Mary	Katherin	ie Edv	vards	
sand Is ma		19a. Informant's Name/Relations Michael McGee/				ng Address (Street					
Health em 27 ther t		20a. Method of Disposition	5011	20h F		Bellows	Court !	l'Owson, M	<del>-</del> -	and 2120 ecation - City or	
ment of tant: If its jury or o		1 ☐ Burial 24XCremation 4 ☐ Donation 5 ☐ Other (S		State Ev	cemetery cre ans Fui pel- Be	<sup>matory</sup> ocother pla neral el Air	; 5,	vember , 2007	For	est Hi	ll, Maryla
Depart Import any in		21. Signature of Funeral Service	Licensee	/	P	2. Name and Addre	as of Facility Iternat	ives Fun	eral	&Crema	tion Ctr.,
		231 Part Enter the disease, o shock, or heart failure. List	complications that	caused the deat		2325 YOUR	Road :	rimonium,	Mary	rland 2	L093 Approximate
ıysician		Immediate Cause (Final		each line.  DISEAS			··g,	end of roophuloty	arroot,		Interval Between Onset and Death
Medical		disease or condition resulting in death)	a.	or as a conseq							
caminer	Ļ	Sequentially list conditions,	b								
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events	Due to	(or as a conseq	juence or):						
physician and s the burial-transit		resulting in death) Last	c	(or as a conseq	juence of):						
ittending or use as	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐Live I	tcome pf pregna pirth 2 □ Feta nant at time of c own	al death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	у		2	23d. Date of del Month	livery Day Year
n signed by the a Id be detached f	by	Part II. Other significant conditi	ons contributing to d	eath but not res	ulting in the u	nderlying cause giv	ven in Part I.		tobacco u		the cause of death?
s been s	Completed							24a. Wa		24b. Were au	utopsy findings availat
	mo			<u>.</u>					opsy formed? 2 <b>X</b> No	death?	completion of cause o : 2□ No
ate has page 2	Be C	25. Was case referred to medica examiner?						Death (Check only			
ertificate ha		1 ☐ Yes 2 No	Hospital: 1  28a. Date	Inpatient 2	ER/Outpatier		4 LI Nursin				cify) HOSPICE
ate	2			th, Day Year)	Injury	Wor	rk? ∣Yes 2∐No	28d. Describe	now injury	y occurred	
ı. After this certificate funeral director, paç		27. Manner of Death  1 X Natural 5 ☐ Pendir  2 ☐ Assident investi				reet, factory, office		28f. Location City or To	(Street and	d Number or Ru	ural Route Number,
er death. rector: After this certificate by the funeral director, pag		**	gation not be 28e. Place	of injury - At hoing, etc. (Specif	ome, farm, str			Ony or re	JWII, Slate,	/	
4 hours after death.  Funeral Director: After this certificate cely filled in by the funeral director, pag	Certification:	1 X Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  1 X Certifyir	gation not be lined 28e. Place build ng Physician: To the Examiner: On the b	best of my knoasis of examina	fy)  owledge, deatl	h occurred at the ti	me, date and p	lace, and due to th	e cause(s)	and manner as	s stated. e to the cause(s)
4 hours after death.  Funeral Director: After this certificate cely filled in by the funeral director, pag		1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only)  1 Certifyir	gation not be 28e. Place build ng Physician: To the Examiner: On the band man	ing, etc. (Specif	fy)  owledge, deatl	h occurred at the ti vestigation, in my o	opinion, death o	lace, and due to th	e cause(s) e, date and	and manner as	e to the cause(s)
er death. rector: After this certificate by the funeral director, pag	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  1 Certifyir 2 Medical	gation not be 28e. Place build ng Physician: To the Examiner: On the band man	best of my knoasis of examina	fy)  owledge, deatl	vestigation, in my	ppinion, death of	lace, and due to th	e cause(s) e, date and 29d. Date	and manner as I place, and due	th, Day, Year)

			For State Registrar	State of Man		artment of H		d Mental Hygi	ene g. N <del>2</del> 0 0 7	34909
			Decedent's Name (First, Middle, Last)	1				2. Date of Death Month	Day Yea	3. Time of Death
	Physicia /Medic		Paul J. Heckman,	Sr.				10-24-20	07	530 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of D	eath	4c. County of De	ath
			917 Chesney Lane 5. Social Security Number 6. Sec	7 Age //	In yrs. last birthday)	Bel Air	If Under 24 I	Hrs. 8 Date of Birth	Harford	irthplace (State or Foreign
	Funeral Director			M 2□F	62 Yrs.	Months Days		Hrs. 8. Date of Birth (Month, Day, 07–25–19	945 M	Country) aryland
	D.		Usual Residence of Decedent							10d. Inside City Limits
	arylan ehow	_	10a. State 10b. County		Oc. City, Town or Lo	cation				1 Tyes 2 No
	Be-f	Director	Maryland Harfor  10e. Street and Number	d	Bel Air	10f. Zip Code		10	og. Citizen of What	
	with t	ā				21014			U.S.A.	,-
	death me 23	era	917 Chesney Lane	12. Was Decedent Eve	er in U.S. 13.		spanic Origin'	? (Specify Yes or No-		merican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or itema 23a or 28e-f show any figury or other traumatic event, the Michigal Examinant the motified at another.	by Funeral	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:		1 Tes, specify Cubai 1 ☐ Yes 2 🛱 No	Specify:	uerto riicari, etc.,	Specify:	White
Ö	2 hou	ted	15. Decedent's Edu		16a. Dece	dent's Usual Occupa	ition		16b. Kind of Busine	
215	thin 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,	)		T	
2	led wi ygien her th	Con	12		Tech	nician	19 Mother's	Name (First, Middle, M		ipment Co.
Maryland 21215-0036	i be fi	Be	17. Father's Name (First, Middle, Last) Wilfred P. Heckma	n				L. Russell	langon comanno,	
Ž	should nd Me mark matic	ဥ	19a. Informant's Name/Relationship (7)		19b. Mailir	ng Address (Street a	and Number o	r Rural Route Number,	City or Town, State	a, Zip Code)
Z	nd 2		Jacqueline Heckma	n (Wife)	917 C	hesney La	ne Bel	Air, MD 2	1014	
ore,	as 1 a of Hei of Hei of Hei r othe		20a. Method of Disposition 1 文Burial 2 ☐ Cremation 3 ☐ F		20b. Place of Dispo cemetery, crer	sition (Name of matory or other place	9)	Date 2	20c. Location - City	or Town, State
<u><u>E</u></u>	Page ment ant: if ury o		4 ☐ Donation 5 ☐ Other (Specify)	demovar from State			The second second second	-27-2007 E	Bel Air,	Maryland
Baltimore,	permit. Departinements any injusting		21. Signature of Funeral Service Licens	<del>00</del>		Name and Addres  610 W.		Schimunek F ail Rd Bel		me of Bel Air 21014
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused th						Approximate Interval Between
a.	Physician		Immediate Cause (Final disease or condition	R	spiras	tom to	sikur	e		Onset and Death
п	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):	1.0	1	VNX:		
1		J.	Sequentially list conditions, if any, leading to immediate	Due to (or as a 6	ansequence of):	- mall	z mer	of tofte		no fres
	uted d ansit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events							
ó	ite be executed lysicien end ne buriat-transit	Exa	resulting in death) Last	Due to (or as a c	consequence of):					
8760,		Ical		d						
Ö	entifica ling ph	Med	IF FEMALE:	23c. If yes, outcome of	processor				224 P-11-4	deline
Вох	death certifica e ettending ph ad for use as t	Physician/Med	in the past 12 months?	1 Live birth 2 4 Pregnant at tin	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
P.O.	res that the de signed by the e be detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown						
	law requires that the es been signed by th 2 should be detache	by Pt	Part II. Other significant conditions co	ntributing to death but i	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob		to the cause of death?
īds	w require been sig should b							1Ye	s 2 □ No 3 1	Probably 4 Unknown
Records,	e law re hes be je 2 sho	Completed						24a. Was at autops	y prior	autopsy findings available to completion of cause of
=	Th ate pag	Con						perform 1 ☐ Yes	ned? death No 1□\	es 2□ No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		at 30 DOA Othe	200	Death Check only on		
ō		1.	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time o	IL SCIDON	4 🗆 140131	ng Home 5 Reside	w injury occurred	респу)
lon	Attending ir death, ector: After by the fune	ation	Natural 5 Pending 2 Accident investigation	(Month, Day Y	/ea <i>r)</i> Injury		<br Yes 2 □ No			
Division of Vital	or Attendi Iffer death, Director: A in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury building, etc.	/ - At home, farm, st (Specify)	reet, factory, office		28f. Location (St. City or Town	reet and Number of n, State)	Rural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edicai Ce	(Check only 2 Medical Exam	sician: To the best of iner: On the basis of e	xamination and/or in	h occurred at the tin vestigation, in my o	ne data and p pinion, death	lians and due to the ca occurred at the time, do	ate and place, and	as stated. due to the cause(s)
	thin 2 the of the implet	Med	29b. Signature and title of certifier	and manner state	0.	29c. License	e number	2	9d. Date signed (M	onth, Day, Year)
	F3F8		Na.11/h	en no		DI	1658	7	Ochba	26, 2007
/	7		30. Name and address of person who c	ompleted cause of dea	th (Item 23a) (Type.		73/3			26, 2007
0			Paul Chang ;	7505 056	n Done,	54 30	2,10	uson, M.	0 2120	3 4
	Sta		31. Date filed (Month, Day, Cear)	32. Aegistrar	s Signature	roade a	/	,		
, in	Regist	ar	001317	JUI JUIL	d Jan Jan					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend istate 37 Maryland & Bepartment of Health and Mental Hygiene 7 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Month 1620 Brandon Timothy 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Upperchesapeake Medical Center Harford Bel Air 8. Date of Birth (Month, Day, Yea 10/20/0 Birthplace (State or Foreign Country) Social Security Number 11 A 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Min. 1 M 2 □ F MD Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show traumatic evant, the Mudical Examiner must be notified at 1 Yes 2 No Director Bel Air Maryland | Harford 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō 238 1410 Purdue Ct. 21014 USA death Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) , or itams 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. parmit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygians. Important: If itam 27 is marked other than "natural", or Itan any injury or other traumatic event, the Model Establish 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Katherine Tracey Timothy Dennis Hilyard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy D. Hilyard / Father 1410 Purdue Ct., Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Zion U.M. Church 10-25-07 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. 22. Name and Address of Facility.
McComas Funeral Home, P.A. 21. Signature of Euneral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart fallure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death . Immediate Cause (Final disease or condition resulting in death) Physician anoxic proun /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 ☐Ectopic pregnancy for Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No should be detachad 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ metabolic 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 (Minpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 1⊈Yes 2□ No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 5 Pending Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident uld not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🕑 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier Maura Caway De Wallese mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D0064824 ucmic, soo u chesapeake Dr. Bel Air MD 21014 Marie Kanagie-McAleesemo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 1 2007 Registrar DHMH 17 Rev 1/2001

Permit call permit be executed be secuted and 2 should be filted within 72 hours after death with the Maryland and Medical Examiner.  From Insportant if item 27 is marked other than "natural", or items 23s or 28s-f show any plury or other traumatic event, its Medical Examiner and insportant if item 27 is marked other than "natural", or items 23s or 28s-f show any plury or other traumatic event, its Medical Examiner and plury or other traumatic event in the Medical Examiner and plury or other traumatic event in the Medical Examiner and plury or other traumatic event in the Medical Examiner and plury or other traumatic event in the Medical Examiner and plury or other traumatic event in the Medical Examiner and plury or other traumatic event in the Medical Examiner and plury or other traumatic event in the Medical Examiner and plury or other traumatic event in the Medical Examiner and plury or other traumatic event in the Medical Examiner and plury or	A-IZ-4545  al Residence of Decedent  State 10b. County  Cyland Harford  Street and Number  7 Northview Place  Marital Status    Never Married 22 Married   Married 3 Widowed 4 Divorced  15. Decedent's Edit (Specify only highest grace)  lementary/Secondary (0-12) 10  Father's Name (First, Middle, Last)  Charles (unk)  Informant's Name/Relationship (7)  ean James Hoffma:  Method of Disposition  12 Burial 2 Cremation 3   Image: Companion of the Com	A HOFFMAN  street and number)  L HOSPITAL  X 7. Age (In yrs. 1)  10c. City  Bel  12. Was Decedent Ever in U. Amed Forces?  1 Serve Year or Dates:  College (1-4or 5+)  Wolcott  Wolcott  Wolcott  Amed Forces?  1 Serve Year or Dates:  College (1-4or 5+)  Wolcott  Wolcott  Wolcott  Wolcott  Hice  Hice	y, Town or Loc  Air  S. 13. v  16a. Decec (Give life. I  7 NOr  Place of Disponementary, crar ghview	HAVRE I  If Under 1 Year Months Days  cation  10f. Zip Code 21015  Was Decedent of If Yes, specify Cut 1 Yes 250 No dent's Usual Occu kind of work done DO NOT use retire  ceria Mar	Hours M  Hispanic Origin? Jan, Mexican, Pu  Specify: Janger  18. Mother's M  Helen  Helen  Land Number of	(Specify Yes or Noverto Rican, etc.)  (Space of Birt. (Month, Da Sept. 2)  (Specify Yes or Noverto Rican, etc.)	Day Year 28, 2007  4c. County of Death HARFORD  the Year 1922 Mar 10g. Citizen of What County of Death County	nplace (State or Foreign unity) Yland  10d. Inside City Limits 1 □ Yes 2 ØNc unity?  rican Indian, e, etc.  iite Industry  Ication
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland be strained by the attending physicien and be permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland be permit the marked other than "notural," or items 23s or 28s-1 show any night of other than "notural," or items 23s or 28s-1 show any night of other than "notural," or items 23s or 28s-1 show any night of other than "notural," or items 23s or 28s-1 show any night of other traumatic event, if a wadral Eram near than any night or other traumatic event, if a wadral Eram near than any night or other traumatic event, if a wadral Eram near than any night or other traumatic event, if a wadral Eram near than any night or other traumatic event, if a wadral Eram near than any night or other traumatic event, if a wadral Eram near than any night or other traumatic event, if a wadral Eram near than any night or other traumatic event, if a wadral Eram near than any night or other traumatic event, if a wadral Eram near than any night or other traumatic event, if a wadral Eram near than any night or other traumatic event, if a wadral Eram near than any night or other traumatic event, if a wadral Eram near than any night or other traumatic event, if a wadral Eram near than any night or other traumatic event, if a wadral Eram near than any night or other traumatic event, if a wadral Eram near than any night or other traumatic event, if a wadral Eram near than any night or other traumatic event in the wadral Eram near than any night or other traumatic event in the wadral Eram near than any night or other traumatic event in the wadral Eram near than any night or other traumatic event in the wadral event in the wadral event in the wadral event in the wadral event in the wadral event in the wadral event in the wadral event in the wadral event in the wadral event in the wadral event in the wadral event in the wadral event in the wadral event in the wadral event in the wadral event in the wadral event in the wadral event	HARFORD MEMORIAN  cotal Security Number 6. Security Number 6. Security Number 6. Security Number 10-12-4545  al Residence of Decedent  State 10b. County  Cyland Harford  Street and Number 7  Northview Place  Marital Status 9  Ma	L HOSPITAL  x   M 2	y, Town or Loc  Air  S. 13. v  16a. Decec (Give life. I  7 NOr  Place of Disponementary, crar ghview	HAVRE I  If Under 1 Year Months Days  cation  10f. Zip Code  21015  Was Decedent of If Yes, specify Cut 1 Yes 2 No dent's Usual Occur kind of work done DO NOT use retire  ceria Man  ng Address (Stree cthview I  position (Name of matory of other pl.)	Hispanic Origin? Jan, Mexican, Published  Pager  18. Mother's Interpretate of the page of	(Specify Yes or Noverto Rican, etc.)  Name (First, Middle, Cathering Rural Route Numbers)	HARFORD  th Year)  102, 1922 Mar  103. Citizen of What Cor  USA  14. Race - Amer Black, White Specify: Wh  16b. Kind of Business/  Public Edu  Maiden Sumame)  ne Rinehart er, City or Town, State, 2	nplace (State or Foreign unity) Yland  10d. Inside City Limits 1 □ Yes 2 ØNc unity?  rican Indian, e, etc.  iite Industry  Ication
permit. Pages 1 and 2 should be filted within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural, or items 23e or 28e-f show any njury or other traumatic event, its Maryland and any njury or other traumatic event and any njury or other traumatic event and any njury or other traumatic event and any njury or other traumatic event and any njury or other traumatic event and any njury or other traumatic event and any njury or other traumatic event and any njury or other traumatic event and any njury or other traumatic event and any njury or other traumatic event and any njury or other traumatic event and any njury or other traumatic event and any njury or o	State 10b. County  Cyland Harford  Street and Number  7 Northview Place  Marital Status    Never Married 22 Married 3 Widowed 4 Divorced  (Specify only highest grace  lementary/Secondary (0-12)  10  Father's Name (First, Middle, Last)  Charles (unk)  Informant's Name/Relationship (7)  ean James Hoffman  Method of Disposition  12 Burial 2 Cremation 3 1  Method of Disposition  13 Burial 2 Cremation 3 1  4 Donation 5 Other (Specify  Signature of Funeral Service Licenses)  a. Part 1. Enter the disease, or composhock, or heart failure. List only considered Cause (Final lease or condition	Bel  12. Was Decedent Ever in U. Armed Forces?  1	S. 13. V. 16a. Decedor Give life. Cafet  19b. Mailin 7 NO1  Place of Disposementary, crar ghview	was Decedent of if Yes, specify Cut 1 Yes 2 No dent's Usual Occur kind of work done of NOT use retinated Manage Address (Streeth View Institute of Name of matory of other plantage of other plantage of other plantage of the position (Name of matory of other plantage)	Hispanic Origin?  Joan, Mexican, Pu  Specify:  Pation  Addring most of ed)  18. Mother's  Helen  It and Number of elace, E	working  Name (First, Middle,  Catherin  Rural Route Numb	USA  14. Race - Americal Black, White Black, White Specify: Wh  16b. Kind of Business/  Public Edu  Maiden Sumame)  ne Rinehart  er, City or Town, State, 2	1 □ Yes 2 ②No untry? rican Indian, e, etc. Lite Industry
be detached for use as the burial-transit  by Physiclan/Medical Examiner  by Physiclan/Medical Examiner  by Physiclan/Medical Examiner  by Physiclan/Medical Examiner  by Physiclan/Medical Examiner  cap a	Street and Number  7 Northview Place Marital Status      Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edit (Specify only highest gradelementary/Secondary (0·12)  10  Father's Name (First, Middle, Last)  Charles (unk)  Informant's Name/Relationship (Tigen)  Method of Disposition  12 Burial 2 Cremation 3 Divided (Specify)  Signature of Funeral Service Licenses  A Part 1. Enter the disease, or composhock, or heart failure. List only considiate Cause (Final lease or condition)	2 12. Was Decedent Ever in U. Armed Forces? 1	S. 13. v. 16a. Decec (Give life. L. Cafet  19b. Mailir 7 Nor	21015 Was Decedent of If Yes, specify Cut  1 □ Yes 2 ☑ No dent's Usual Occu kind of work done DO NOT use retira  Terria Man  and Address (Street Cthview I  Desition (Name of matory of other pl.)	Hispanic Origin?  Joan, Mexican, Pu  Specify:  Pation  Addring most of ed)  18. Mother's  Helen  It and Number of elace, E	working  Name (First, Middle,  Catherin  Rural Route Numb	USA  14. Race - Americal Black, White Black, White Specify: Wh  16b. Kind of Business/  Public Edu  Maiden Sumame)  ne Rinehart  er, City or Town, State, 2	nican Indian, e, etc. hite Industry
be detached for use as the burial-transit  be detached for use as the burial-transit  be detached for use as the burial-transit  be detached for use as the burial-transit  be detached for use as the burial-transit  by Physician/Medical Examiner  by Physician/Medical Examiner  by Physician/Medical Examiner  by Physician/Medical Examiner  by Physician/Medical Examiner  cansat and a second of the physician of the	a. Part1. Enter the disease, or comp shock, or heart failure. List only conditions are conditions.	Horack	22		l Grdn 1		20c. Location - City or Fallston, M	
igned by the attending phy be detached for use as the bedetached for use as the by Physiclan/Medic	ulting in death)  quentially list conditions, try, leading to immediate se. Enter Underlying use (Disease or injury t initiated sevents ulting in death) Last	one cause on each line.	h. Do not ent	1317 Coke ter the mode of dy 2017	ring, such as car	carl, Abirdiac or respiratory a	gdon, Maryl	Approximate Interval Between Onset and Death
igned be detr	FEMALE:  b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unknown	23c. If yes, outcome of pregnation to the pregnant at time of cells and the pregnant at time of cells are the pregnant at time of cells and the pregnant at time of cells are the pregnant at time of cells and the pregnant at time of cells are the pregnant at time of cells are the pregnant at time of cells are the pregnant at time of cells are the pregnant at time of cells are the pregnant at time of cells are the pregnant at time of cells are the pregnant at time of cells are the pregnant at time of cells are the pregnant at time of cells are the pregnant at time of cells are t	ideath 3[	□Ectopic pregnan □ Other <i>(specify)</i>			23d. Date of de Month	livery Day Year
cate has been single 2 should	III. Other significant conditions of	ontributing to death but not res	sulting in the u	underlying cause (	gven in Part I.	1 □ : 24a. Was auto	s an 24b. Were an prior to death?	o the cause of death?  robably 4 Unkno  utopsy findings availa completion of cause  s 2 No
After this certification: To Be Clon; To B	Was case referred to medical examiner?  1  Yes 2 No  Manner Death 1  Natural 5  Pending investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	ol 28c. In W	other: 4 ☐ Nursii ury at lork? ☐ Yes 2 ☐ No	28d. Describe	one) idence 6 Other (Spe	əcify)
itel or ris efter al Dir. led in led in Cert	3 Suicide 4 Homicide 6 Could not be determined	building, etc. (Speci	fy) owledge, deal	th occurred at the	time, date and p	City or To	(Street and Number or Rown, State)  cause(s) and manner a	s stated.
To the Hosping Within 24 hour for the Fundant of th	(Check only 2 Medical Examone)	niner: On the basis of examination and manner stated.	ation and/or in	nvestigation, in my	y opinion, death	occurred at the time	date and place, and du 29d. Date signed (Mon Ocfober  Bel Ac	e to the cause(s)

Catherine F. Hoffman Silsmin

		•	For State Registrar	State of Maryl	•	rtificate of l		Reg. I	Z U U /	34912
	n of the state of		1. Decedent's Name (First, Middle, Last	)				2. Date of Death		3. Time of Death
	Physicia /Medic		MARLENE ROSALIE	HIRSCH				OCT	29 2007	152 AM
	Examin	395	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Death	
			5. Social Security Number 6. Se	and heha	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	MUNTO!	ce (State or Foreign
	Funeral Director			☐M 25☑F	57 Yrs.	Months Days	Hours Min.	June 24,	1940 Mary	y) ·
	ס		Usual Residence of Decedent					ouic 24,		
	arylar ahow	_	10a. State 10b. County	10c.	City, Town or Lo	ocation			100	d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he M	ecto	Maryland Harford  10e. Street and Number	Be	el Air	104 7in Code		100	Citizen of Miles County	
	with	i	1307 Sheridan Pla	ICO.		10f. Zip Code 21015		US	Citizen of What Countr	y :
	death ms 23	Funeral Director	11. Marital Status	12. Was Decedent Ever i	n U.S. 13.	Was Decedent of H	ispanic Origin? (Spe	acity Yes or No-	14. Race - American	
9	or ite	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No If Yes, Give		lf Yes, specify Cuba 1 □ Yes 2√□ No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, White, et	c.
21215-0036	72 hours after death with the Maryland natural', or Items 23s or 28s-f ahow dical Examinet must be motified at	d by	3 Widowed 4 Divorced	Year or Dates:					Specify: Whi	
15	n 72 i	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	(Give	dent's Usual Occup: kind of work done o DO NOT use retired	during most of worki	ing 16b.	, Kind of Business/Indu	stry
212	i within iiene.	d mo	Elementary/Secondary (0-12)	College (1-4or 5+)		maker	,	C	wn Home	
פ	be filed within tal Hygiene. Id other than avent, it e Me	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Maid		
ylaı	2 should be and Mental Is marked raumatic av	ToE	Herman (unk) F	Rebbert			Viola	(unk) Hor	ne	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic avent. Ite Medical Exerciper must be rediffed at		19a. Informant's Name/Relationship (T	ype, Print)					ty or Town, State, Zip C	
	1 and 2 Health em 27 l	1	John E. Hirsch / 20a. Method of Disposition		b. Place of Dispo				Air, MD 2 Location - City or Tow	
nor	ages int of t: If it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	cemetery, crei	natory or other plac	:e)		100.00	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.	9 1	21. Signature of Funeral Service Licens		Hillton	Service C	orp: 11-1 ineral Hon		wson, Mary	land
m	Depa Impo any I	J 7	Attale (1)	walus	1	ocomas ru 317 Cokes	neral Hon bury Road	ne, P.A. 1. Abinado	n, Marylan	d 21009
74		8	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the one cause on each line.					- 1	Approximate nterval Between
45	Physician		Immediate Cause (Final disease or condition	, Deme	itica	With F	ailup	to the	nue	Onset and Death
4.0	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):					
		er	if any, leading to immediate	b. Due to (or as a con	sequence of):					
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							3
o,	e exec an an rrial-tr		resulting in death) Last	Due to (or as a con	sequence of):					
58760,	ficate be executed physician and s the burial-fransit	edicai	•	d						
_			IF FEMALE:	23c. If yes, outcome of pre	anancy					
Вох	death certii e attending d for use a	cian	in the past 12 months?	1 ☐ Live birth 2 ☐ F	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month D	/ Pay Year
O.		Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	-					
ď.	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tobacc	co use contribute to the	cause of death?
ord	w require been sig should b							1 ☐ Yes	2 ☐ Ho 3 ☐ Probat	oly 4 Unknown
Records,	e taw r has be	Completed						24a. Was an autopsy	rior to com	y findings available pletion of cause of
E E	Th ate pag							performed	? death? No 1 ☐ Yes 2	CINO
Vital	Physician: The this certificate hirral director, page	Be	25. Was case referred to medical examiner?	Hospital:	- C.50/0 · · · ·	Othi		(Check only one)		
of			1 Yes 2 No				Hi and		6 ∐Other (Specify)	
9	<b>문</b> 도 교	J: To	27. Manner of Death	28a, Date of Injury	2 ER/Outpatier 28b. Time o	IT 3 DOA	4 Nursing Ho	me 5 Hesidence 28d. Describe how in	njury occurred	
ion	Jing Ph J. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time o	28c. Injun	4 Nursing Ho		njury occurred	
ivision c	Jing Ph J. After th funeral		1 Natural 5 ☐ Pending	28a, Date of Injury	28b. Time o Injury	28c. Injury Work	4 Nursing Ho y at k? Yes 2 □ No	28d. Describe how in	and Number or Rural	Route Number,
Division o	Jing Ph J. After th funeral	Certification:	1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  5 ☐ Pending investigation 6 ☐ Could not be determined	28a. Date of Injury (Month, Day Yea 28e. Place of Injury - J building, etc. (Sp	28b. Time o Injury At home, farm, str ecify)	f 28c. Injun World M 1 1	4 Nursing Ho √ at k? Yes 2 □ No	28d. Describe how in 28f. Location (Street City or Town, St	t and Number or Rural i ate)	
Division	Jing Ph J. After th funeral	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Yea 28e. Place of Injury - A	28b. Time o Injury  At home, farm, strecify)	f 28c. Injun Work M 1 1	Yes 2 No	28d. Describe how in 28f. Location (Street City or Town, St	and Number or Rural (ate)	ted.
Division	Jing Ph J. After th funeral		1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only)  1 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Yea  28e. Place of Injury - A building, etc. (Sp	28b. Time o Injury  At home, farm, strecify)	f 28c. Injun Work M 1 1	y at	28d. Describe how in 28f. Location (Street City or Town, St and due to the cause ed at the time, date :	and Number or Rural (ate)	ned. he cause(s)
Division	ding Ph h. After th funeral	edical Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  1 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Yea  28e. Place of Injury - A building, etc. (Sp	28b. Time o Injury  At home, farm, strecify)	f 28c. Injun Work M 1 1 reet, factory, office	y at	28d. Describe how in 28f. Location (Street City or Town, St and due to the cause ed at the time, date :	and Number or Rural i ate) a(s) and manner as stal and place, and due to t	ned. he cause(s)
Division	Jing Ph J. After th funeral	edical Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28a. Date of Injury (Month, Day Yea  28e. Place of Injury - A building, etc. (Sp	28b. Time o Injury  At home, farm, strecify)  knowledge, death	eet, factory, office  a cocurred at the time vestigation, in my of	y at	28d. Describe how in 28f. Location (Street City or Town, St and due to the cause ed at the time, date :	and Number or Rural i ate) a(s) and manner as stal and place, and due to t	ned. he cause(s)
Division	Jing Ph J. After th funeral	Medical Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28a. Date of Injury (Month, Day Yea  28e. Place of Injury - A building, etc. (Sp. reician: To the best of my iner: On the basis of exan and manner stated.	28b. Time o Injury  At home, farm, strecify)  knowledge, death innation and/or in	eet, factory, office  a cocurred at the time vestigation, in my of	y at	28d. Describe how in 28f. Location (Street City or Town, St and due to the cause ed at the time, date :	and Number or Rural i ate) a(s) and manner as stal and place, and due to t	ned. he cause(s)

mariene Hirsch

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:17 5m October 20 2007 Elizabeth Virginia Hyatt 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Rockville Montgomery Shady Grove Adventist Hospital Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 1/1/1937 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex 1 □ M 2 🕏 👍 Pennsylvania 70 167-30-7936 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 1 ☐ Yes 2 X No Montgomery Germantown 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 20874 USA 18346 Timko Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Black. White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🛣 No Specify Specify: White 3 ☐ Widowed 4 🕅 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) - tions College (1-4or 5+) Elementary/Secondary (0-12) Nursing/Telecommunica-Nurse/ Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Irene Kyler <u>Charles David Javens</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 18220 Mehrens Terr. Olney, MD 20832 Bernadette Lund/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 10/26/2007 Brentwood, MD 22. Name and Address of Facility Silver Spring, MD 20910 21. Signature of Funeral Service Licensee tisled Tolenvann Rapp Fun. & Crem. Svcs. 933 Gist Ave 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kadiatier Due to (or as a consequence of): 115 Due to (or as a consequence of). CACHOL Due to (or as a consequence of IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 | Fetal death Month Year in the past 12 months? 23e. Did tobacco use contribute to the cause of death? Part if. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 2 No

Physician /Medical **Examiner** 

burial-tran

the as

physician

ed by the attending detached for use as

director,

after death | Director: / d in by the f

n 24 hours aft ie Funeral Di eletely filled in

completely within 2.

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

**Physician** 

/Medical

10a. State

MD

Examiner

**Funeral** 

Director

28a-f show

Director

à

Completed

Be

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

filed within 72 hours after Hygiene.

es 1 and 2 should be fil of Health and Mental H f item 27 is marked ott

Pages 1 o =

permit, Page Department o Important: If any Injury or Injury or

altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be

Hospital or Attending Physician:

Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

9 ☐ Unknown

24a. Was an autopsy performe /es 2

1⊟ Yes

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No

25. Was case referred to medical examiner?

1 Dinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 🔲 Yes 27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide

4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be determined

28b. Time of (Month, Day Year) Injury 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Germanteun MD 20874

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day,

3 OCT

29 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Deckeri Drive

	For State of Maryland	Certificate of Death	Reg. No 2 0 0 7 3 4 9 1 4
Physician /Medical	Decedent's Name (First, Middle, Last)	arris	2. Date of Death Month Day Year Z3Z M
Examiner	4a. Facility Name (If not institution, give street and number)	Baltimure, N	4c. County of Death N/A
Funeral Director	5. Social Security Number 218 84 9342 6. Sex 7. Age (In yrs. Ia 35	Ast birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)  JUNE 6,1972 MD.
ges 1 and 2 should be filed within 72 hours after death with the Maryland ges 1 and 2 should be filed within 72 hours after death with the Maryland to fleath and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other fraumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City,  MD ■ N/A  10e. Street and Number 2927 EDISON HIGHWAY  11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	BALTIMORE  10f. Zip Code 21213  3. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	10d. Inside City Limits  1 ☆ Yes 2 □ No  10g. Citizen of What Country?  USA  acify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: BLACK
tally judicial of the first 15-00-02 should be filed within 72 hou and Mental Hygiene. Is marked other than "natura aumatic event, the Medical E  To Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  1 O TH  17. Father's Name (First, Middle, Last)  CORNEL HARRIS		TEST COLLEGE (First, Middle, Maiden Surname)
Vical y Ica 12 should I h and Men 7 is marke traumatic	19a. Informant's Name/Relationship (Type. Print) PATRICIA HILL (mother)	19b. Mailing Address (Street and Number or Rural 4638 Parkside Dr. 1	
pdattiliore, ivi	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State  20b. Place	ace of Disposition (Name of emetery, crematory or other place)	20c. Location - City or Town, State  3,2007 BALTO, MD.  GS FUNERAL HOME
requires that the death certificate be executed requires that the death certificate be executed with many squared by the attending physician and required by the attending physician with the provided by Physician/Medical Examiner	23a. Part1. Enter the disease, or complications that caused he death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conditions of the cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of the conditions of the cause) Last only one cause on each line.  Due to (or as a consequence of the conditions of the cause) Last only one cause on each line.  Due to (or as a consequence of the cause) Last only one cause on each line.	lence of):	Interval Between Onset and Death
w requires that the death certiful should be detached for use a should be detached for use a letted by Physician/Meleted by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown  23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
ires that the signed by lbe detacted by Phy	DR TO		23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknow
VItal Records sician: The law requires certificate has been sign frector, page 2 should be BE Completed by	resection append	dectomy	24a. Was an autopsy findings available prior to completion of cause of death?  1 □ res 2 □ No 1 □ Yes 2 □ No
	25. Was case referred to medical examiner?	Othor	h Check onl one
To the Hospital or Attending Physical Within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.  Medical Certification: To		28b. Time of Injury M 28c. Injury at Work? M 1 Yes 2 No	ome 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)
o the Hospital ithin 24 hours the Funeral ompletely filled		wledge, death occurred at the time, date and place, tion and/or investigation, in my opinion, death occur	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)
To the within To the comple	29b. Signature and title of certifier	29c. License number  P7 - () 9 F	29d. Date signed (Month, Day, Year)
2	30. Name and address of person who completed cause of death (Item	123a) (Type, Print)  5. Greene St ?	caltimore, MD ZIZO)
State Registrar	24 Date Class (March Day Shall 22 Bernietran's Signal		
DHMH 17 Rev 1/200		ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 03:15 P<sub>M</sub> OCTOBER 28 2007 MORTON J HESS JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON 6. Sex 1**X** M 2 □ F 5. Social Security Number Birthplace (State or Foreign Country)
 MD Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours Min Director 220-18-8376 83 07/28/1924 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show MD N/A 1 Yes 2 No Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 2605 TANEY ROAD 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 🕻 Married "natural", or 1 ☐ Yes 2 🛣 No Specify. WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REAL ESTATE **PROPRIETOR** Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked J. MORTON HESS, SR. MYRTLE 2 GRISSIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SELMA HESS / WIFE 2605 TANEY ROAD. BALTIMORE, MD Important: if item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Burial 2 □ Cremation 3 DRemoval from State 5 ☐ Other (Specify) 10/30/2007 4 Donation HEBREW FRIENDSHIP BALTIMORE, MD 21. Signature of Funeral Service License SOL LEVINSON & BROS., INC. 22. Name and Address of Facility Molloce 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or compli-ation. Sat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Weeks /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending phase as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) Day Year 4☐Pregnant at time of death Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes AZ No 3 Probably 4 □Unknown Completed 24a. Was an . Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No perform To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 271Ho 2 2 ER/Outpatient 3□ DOA Inpatient this s after death. 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year)

10

State Registrar Name and ad

31. Date filed (Month, Day,

and

DHMH 17 Rev 1/2001

(ess of person who completed cause of death (Item 23a) (Type, Print)

69

32 Registrar's Signature

Hartiss	St 1- For State	ate of Maryla		tment of ficate of		Mental Hy	giene Reg. N	200	7 31.0
Physician/	1. Decedent's Name (First, Midd Ricky Harti						Date of Death Month Da October 27, 2		3. Time of Death 1910 hrs
al Examiner	4a. Facility Name (if not institution 1622 Patapsco Street	on, give street and nu	d Shawn Har		o. City, Town, or Lo Baltimore			4c. County of Death	
Funeral Director	5. Social Security Number	6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24Hrs. Hours Min.		M/DD/YYYY) 9. Birth Foreign 21 ,1973 Cour	
ow any	Usual Residence of Decedent  10a. State 10b. County  MD		10c. City, T	own or Location	ltimore			l	10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at once	10e. Street and Number 38 East Heath	Street			10f. Zip Code 21230	)	10g. (	Citizen of What Count	
or items	11. Marital Status 1 Never Married 2 N		2 X No	If Ye	Decedent of Hispans, specify Cuban,  Yes 2 No	Mexican, Puerto F		14. Race - Americ White, etc. Specify: Wh	an Indian, Black,
an "natural", ical Examiner	15. Decedent's Education (Spe Elementary/Secondary (0-12)	ecify only highest gra-	de completed)	16a. Decedent during mo	's Usual Occupation of working life. If	on (Give kind of wo	ork done 16	b. Kind of Business/Ir	
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Complet	17. Father's Name (First, Middle Richard Lee H				18	Katherine Katrin		den Surname) Jowanowit	
ifth and Men a 27 is marl aumatic eve	19a. Informant's Name/Relation Richard Lee Ha			5858		ın Road,	Bunker 1	r, City or Town, State,  Hill, WV 2  Oc. Location - City or	5413
permit. Pages 1 an Department of Hea Important: If ite injury or other tr.	20a. Method of Disposition  1 XBurial 2 Crematic  4 Donation 5 Other S		rom State Cr HO	ematory or oth		ery 10/	31/2007	Baltimo	
executed an and and and transit ransit leaf Examiner		e a. Methado Due to (or as b. Due to (or as c. Due to (or as d.	a consequence of a consequence of a consequence of a consequence of a consequence of	: :					Death
h certificate be lending physici use as the buri	X UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 U	the 23c. If yes 1 Live 4 Preg	nant at time of dea	ancy 2 Feath 5 Ot	tal death 3 her (Specify)	Ectopic pregna	ncy	Month	Day Year
The law requires that the deatl ficate has been signed by the at page 2 should be detached for Completed by Physics		itions contributing	to death but not re	sulting in the u	underlying cause g	iven in Part I.	1 Yes  24a. Was an autopsy	24b. Were au	the cause of death?  pably 4  Unknown  utopsy findings available completion of cause of
ysician: The law his certificate has director, page 2 s	25. Was case referred to medic	<u> </u>				of Death (Check			
tal or Attending Physician: The law require rs after death.  "I Director: After this certificate has been si led in by the funeral director, page 2 should be refification: To Be Completed.	1 Yes 2 No	nding End	e of Injury th, Day,Year)	28b. Time of Fnd 7:05	Injury 28c. Injur	y at Work?	28d. Describe ho	w injury occurred	
Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the funeral Certification:	2 Accident Invalidation of Accident 3 Suicide 6 X Code 4 Homicide 29a. Certifier 4 Code in the code of	buld not be termined (Specify	nce of Injury - At ho	ome, farm, stre	et, factory, office b		or Town, Sta 1622 Pata	psco St. Bal	
To the How within 24 h To the Fur completely	29b. Signature and title of certifying 29b. Signature and title of certifying 29b.	caminer:On the basis and manner	of examination a	ge, death occu nd/or investiga	29c. Licens	, death occurred a	at the time, date ar	(s) and manner as stand place, and due to the 29d. Date signed (Mc	onth, Day, Year)
<b>A</b>	30. Name and address of pers			23a)	O.C.I			October 28, 200	
	Ana Rubio MD. A	ssistant Medical	Examiner	111 Penn :	Street, Baltimo	ore, MD 2120	1		

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #19b,perFD, G872, 10/31/07 TTCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:10 A M 25, 2007 October /Medical HELEN $\mathbf{E}_{-}$ TRWIN 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Under 1 Year | If Under 24 Hrs. Frederick Frederick Memorial Hospital 8. Date of Birth (Month, Day, Year) May 7, 191 Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (In vrs. last birthday) **Funeral** 1 □ M 2**X** F 91 Months Days Hours Min. 025-09-3340 Director 1916 MA Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County show items 23a or 28a-f shov ner must be notified at MA Norfolk Quincy Y⊆Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1000 Southern Artery # 685 02169 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Retail 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Fay Bridget Durkin ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Seminole Court, East Brunswick, 33 Sherwood Farm Road Far Hills, NJ 07931 20b. Place of Disposition (Name of cemetery, crematory or other place) Barbara Jacobs / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/29/2007 Mount Hope Cemetery Boston, MA 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 21. Signature of Funeral Service Licenses W. Moustrall oveta 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate ntervat Between Onset and Death Immediate Cause (Final **Physician** Aspiration Due to (of as a consequence of) il Day disease or condition resulting in death) /Medical Examiner Stroke Sequentially list conditions, in your cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed 21 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2NNo 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Injury (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director / completely filled in by the fi death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier D43091 10-26-67

Registrar
DHMH 17 Rev 1/2001

State

B

Desta J

801

TOLL House Are

Frederick, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jaren

31. Date filed (Month, Day, Year)

Raid 1

MO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 Oh NYON /Medical Sounty of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Éxaminer + moire KANDAllstonn lon thwest If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 219 403824 1 XM 2□F Months Min Yrs 65 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Heaith and Mental Hygiene. 12. Was Decedent Ever in Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Important: If item 27 is marked other than any injury or other traumatic event, the Me once. tharade 17. Father's Name (First, Middle, Last) lohnson 19b. Mailing Address (Street and Number or Rural Route Number, City of idhn<del>s</del>dn 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Columbia Mem Kar 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee aughn Randallstown, MD 21133 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** NELWONIA siva trone /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as attending plant of the last as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the 9□ Unknown detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy performe certificate 1 Yes 2 No Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ဥ 1 ☐ Yes 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 25 2007 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Steven Ruller

31. Date filed (Month, Day, Year)

OCT 3

2007

Road

Court

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		<b>5</b>		ise Type or Pr State of N									•	
				State of Me a per MD,g872	2, 10/3	1/07 J	ertificate c	f Dea	ath			200	7 31	919
Physici /Medio		1. Decedent's Name		ley Sacolo						2. Date of D Month	Day			6 M
Examir		4a. Facility Name (If not institution, give street and number)  Baltimore VA Medical Center					4b. City, Town, or Location of Death Baltimore				4c.	County of De	eath A	
Funeral Director		5. Social Security N 214-30-7081	lumber		Age (In yrs.	last birthda Yrs	ay) If Under 1 Ye	ar If U	Jnder 24 Hrs. ours Min.	8. Date of B	irth 24, Year 19		Birthplace (State Country)	e or Foreign
fand ow		Usual Residence of 10a. State	f Decedent 10b. County		10c. Cit	ty, Town or	Location						10d. Inside	City Limits
he Mary 28a-f sh otified a	ector	Maryland		ltimore	F	Parkvi]								es 2 No
th with t	al Dir	3404 Hiss /					10f. Zip Cod 212				USA	zen of What	Country?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatte event, the Medical Examiner must be notified at one.	Completed by Funeral Director	11. Marital Status 1 □ Never Marr 3 □ Widowed	, ,	I res. Give	s? ] No	.S. 1	3. Was Decedent of If Yes, specify C	uban, M	nic Origin? (S lexican, Puert pecify:	pecify Yes or N o Rican, etc.)		14. Race - Ar Black, W Specify. <b>Wh</b> i		
within 72 ho ene. than "natur the Medical E	ompleted	(Special Special cify only highe	nt's Education est grade completed)  College (1-4c	r 5+)	(G.	cedent's Usual Oc ive kind of work do e. DO NOT use rel uter Operat	ne during ired)		king	16b. Kii	nd of Busines			
ould be filed Mental Hygi arked other atic event, ti	To Be Co	17. Father's Name (First, Middle, Last) George F. Jacob  18. Mother's Name (First, Middle, Maiden Surnan Hilda W. Worthmann							Surname)		1 - 7 - 7 -			
and 2 sho alth and 27 is m		19a. Informant's Na Barbara Ja				19b. Ma	ailing Address (Stre 404 Hiss Av	eet and N 'enue	Parkvi	Ile, Mar	y land	<sup>7</sup> 21234 <sup>ate</sup>	e, Zip Code)	
Pages 1 annument of He		20a. Method of Disp 1 ☐ Burial 2 4 ☐ Donation	Cremation	3 □Removal from Sta	e i		sposition (Name of crematory or other) ervice Corp		10/2	Date 7/07		cation - City nore Ma	or Town, State Cyland	
permit. Departimont		21. Signature of Fu	uneral Service	Licensee  / // Lla			22. Name and Ad Leonard J. 5305 Harfor	Ruck Ruck	Facility Inc. ad Balt	imore Ma	ryland	21214		
Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Approximate Interval Between Onset and Death  Metastatic colon cancer  Due to (or as a consequence of):										Between		
Examiner	ner	Sequentially list con	nditions,	b. Due to (or a	tiple Organ System Railwe as a consequence of.								2 days	prior
e be executed sician and burial-transit	cal Examiner	cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	injury S	c. Sho c		a consequence of):							5 days	prier
the death certificate be y the attending physici ched for use as the bu	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 🗆 Feta	al death	3 □Ectopic pregna 5 □ Other (specify				2	23d. Date of of Month	delivery Day	Year
w requires that the de been signed by the s should be detached to	by	Part II. Other signif	ficant conditi	ons contributing to death	but not res	ulting in the	e underlying cause	given in	Part I.			se contribute	e to the cause	of death?
n: The law re icate has bee r, page 2 sho	Completed				-					24a. Wa aut per Ves	opsy formed?	24b. Were prior death		gs available f cause of
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be	25. Was case referred to medical examiner?  1									lumber,			
e Hospita 24 hours e Funeral letely filled	Medical C	29a. Certifier (Check only one)	Certifyin	ng Physician: To the be Examiner: On the basis and manner	of examina	wledge, de	eath occurred at the investigation, in n	e time, da ny opinio	late and place on, death occu	e, and due to th	e cause(s) e, date and	and manner place, and	as stated. due to the caus	e(s)
To th within To th comp	Me	29b. Signature and title of certifier  MAN AU 417 6435 618308 29d. Date signed (Month, Day, Year)  AU 417 6435 618308 10/23/2007									7)			
7+1		MILL	1.1 M	who completed cause of On Valvas Y of	death (Item	0 23a) (Typ	o Drint\							
Sta Registr		31. Date filed (Mon	OCT	3 1 2007	Frar's Signa	ature &	Sperke							

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and physician the ed by the a detached f cate has been signed bage 2 should be det funeral director, After this n 24 hours at er dea h.
le Funeral Director: Aft within 24

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

1041 State Registrar

DHMH 17 Rev 1/2001

29a. Certifier (Check only

30. Name and eddr

31. Date filed (Month, Day,

29b. Signature and title of certifier

10753 Fellard Lutterville Md 21093 Fire mo T. 32. Raistrar's Signature

and manner stated.

who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

019914

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician October 24, 2007 10:22 AM Nathan Kingsley /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4217 Leland Street Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year)
November 20, 1926

8. Birthplace (Sta Country)
New York 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Hours Days 1**X** M 2 □ F 80 133-16-1544 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Chevy Chase 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4217 Leland Street 20815 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 N Married 1 ☐ Yes 2 No White Specify: WWII Specify 9 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Journalist Radio 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Kingsley Bess (unknown) ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4217 Leland Street, Chevy Chase, Maryland Cynthia Jean Kinglsey/Wife 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 29 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Bethesda, Maryland Montgomery Crematorium 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda-ChevyChase, Inc. 7557 Wisconsin Avenue, Bethesda, MaryLand 20814 21. Signature of Funeral Service License Ulllian sull M01173 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiac Dysrythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease 25 Years Sequentially list conditions, any leading to limit the cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1□Yes 2 No 3 ☐ Ectopic pregnancy Month 4⊡Pregnant at time of death 5 Other (specify) signed by the ar 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform 1 Yes 2X No Attending Physician; ector, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖔 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 🔲 Inpatient ို 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work?

After this funeral filled in by the

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital Records,

To the Hospital or Attendii within 24 hours after death. To the Funeral Director; Al Medical completely

State

Registrar

Certification:

1 Natural

2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

2041

Brian Turrisi, M.D.



29c. License number MD13891

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) October 25, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2440 M Street, NW #810, Washington, D.C.

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

5 ☐ Pending investigation

6 Could not be

determined

(Month, Day Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State of Maryla Registrar		tificate of L			<sup>епе</sup> 2007	34922		
E	Physicia	an	1. Decedent's Name (First, Middle, Last)	Date of Death     Month	Day Year	3. Time of Death					
	/Medic	al	Grace Marie Lanasa  4a. Facility Name (If not institution, give street and number)	4h City Tourn or	Location of Death	10-28-20	4c. County of Deatl	500 p <sup>M</sup>			
	Examin	er	Gilchrist Center		Towson	Location of Death		Baltimore			
	Funeral		5. Social Security Number 6. Sex 7. Age (In year)	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9 Birth	nplace (State or Foreign untry)		
	Director		217-12-6892 1 1 M X F 93	Yrs.	WORKINS Days		07-23-19		land		
d 21215-0036	and ow t		Usual Residence of Decedent  10a. State 10b. County 10c. (	City, Town or Lo	cation				10d. Inside City Limits		
	Maryl -f sho fied a	tor	Maryland Harford	Fores	st Hill				1 □Yes 2/€ No		
	r 28a r notif	Director	10e. Street and Number	rores	10f. Zip Code		10	g. Citizen of What Co	untry?		
	th wit		307 G. Willrich Circle		210			U.S.A.			
	tems	Funeral	11. Marital Status  12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spann, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White			
36	be filed within 72 hours after death with the Marylan tal thygiene.  d other than "natural", or frems 23a or 28a-f show of other than "sale and free and sevent, the Meskal Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 M No If Yes, Give 3 M Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:		Specify: W	Mite		
Maryland 21215-0036	2 hou		15. Decedent's Education	16a. Deced	dent's Usual Occupa	ation	[ ]1	ndustry			
215	ithin 7 le. lan "r	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life. L	kind of work done of DO NOT use retired,	) )					
21	led wi		17. Father's Name ( <i>First, Middle, Last</i> )	Self	Employed	18. Mother's Name		Beautician			
and	e da a	Be c	Samuel Brocato				phine Za	· ·			
	nd 2 should be tth and Menta 27 is marked 17 aumatic er	은	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a		<del>*</del>	City or Town, State, Z	(ip Code)		
	and 2 seaith ar		Marcus Lanasa (Son)	2426	Grand Oa	aks Ct Ab	ingdon.	MD 21009			
more	一工でも				sition (Name of matory or other plac			20c. Location - City or	Town, State		
	Pages ment of I ant: If its			ulaney V	-			imonium, M			
Balt	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Licensee						e of BelAir		
			Inc. 610 W. MacPhail Rd Bel Air, MD 21014  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Check and Death and De								
//	Physician		Immediate Cause (Final disease or condition  Alente dustage  A								
	/Medical		resulting in death)  Due to (or as a cons	/ /			0.00		1		
5	Examiner	_	Sequentially list conditions, b.								
	ed isi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entier Underlying Cause (Disease or injury that initiated events	sequence of):							
_=	execut and al-trar	xan	that initiated events c.  resulting in death) Last Due to (or as a cons	sequence of):							
98760	ificate be executed g physician and as the burial-transit	edical									
			IF FEMALE:								
Box	leath certifi attending I for use as	an/	23b. Was decedent pregnant    23c. If yes, outcome pripred   1   Live birth   2   F	etal death 3	∃Ectopic pregnancy				d. Date of delivery Month Day Year		
- -	The law requires that the death cer ate has been signed by the attendir age 2 should be detached for use	Physician/M	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of 9 ☐ Unknown	of death 5L	Other (specify)						
مذ	that the de ned by the a detached t		Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?		
Records,	tw requires to be a signer should be a	d by	pulmonoy to bri	osis			1 □ Ye	s 2 <mark>⊡N</mark> o 3□Pr	obably 4 □Unknown		
ပ္တ	aw red	olete			24a. Was ar	itopsy findings available					
	sician: The law certificate has t irector, page 2 s	Completed					autops: perforn 1 Yes 2	ned2 death?	completion of cause of 2 ☐ No		
Vital	cian: ertific	Be (	25. Was case referred to medical examiner?		lou	26. Place of Deat	h (Check only one	9)	<i>i</i> /		
	Physical this call dire	ို	1 Yes 2 No Hospital: 1 Inpatient 2  27. Manner of Death 28a. Date of Injury	28b. Time o		4   Nursing Ho		nce 6 Other (Spe	city) HOSPICE		
O	ding P. h. After funer	tion	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?  28d. Describe how injury occurred Work?  1 □ Accident investigation M 1 □ Yes 2 □ No								
Division or	l or Attend after death Director:	ifica	3 Suicide 6 Could not be 28e. Place of injury - A	t home, farm, str	reet, factory, office			Street and Number or Rural Route Number,			
	tal or safte al Dire	Certification:	4 ☐ Homicide determined building, etc." (Specify) City or Town, State)								
	Hospital or Attending Physician: Ad hours after death. Funeral Director: After this certificately filled in by the funeral director,	edical	29a. Certifier 1 Certifying Physician: To the best of my l (Check only one) 2 Medical Examiner: On the basis of exam and manner stated.								
	To the Hosl within 24 ho To the Func completely f	Mec	29b. Signature and title of certifier		29c. License		29	9d. Date signed (Mont	h, Day, Year)		
)	4		1 / thathus the	· us	) D2	2002	Ĉ	ctober 29	,2007		
1	γ		111 /1 /1 / / / / / / / / / / / / / / /	item 23a) (Type,	Print)	lo (+ 1	Bolt.	clober 29 nd 20	2016		
t	Sta	to	31. Date filed (Month, Day, Jear) 32. Registrar's Signary	anaturo e		-> 31. 1	1000				
	Registr		QCT 3 1 2007 Language	AS AD	sales						

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 0 7 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ruth G. October 29, 2007 Lutz 8:15 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Manor Care - Joppa Road Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🔀 I 82 1924 Director 219-18-4415 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits show "natural", or items 23a or 28a-f shovidical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Towson 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Beech View Court 21286 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ Specify: 3 X Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Clerical permit. Pages 1 and 2 should be filed be partment of Health and Mental Hygis Important: If item 27 Is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Gerke Bensel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Akelaitis (daughter) 208 Beech View Court, Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify)

21. Signatur i Funer S ice Licensee Parkwood Cemetery 11/01/2007 Baltimore, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. any 1050 York Road, Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ementia ears /Medical Due o (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical as attending properties IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy performed? Yes 201 No death? 1 ☐ Yes 2 → No certificate l 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation Iniury To the Hospina. Within 24 hours after death.

To the Funeral Director: After a consistent of the funeral bit of the funeral bit of the funeral par 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Oct, 30.2007 mo D606 1/99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Sute 209 Touson Ms 21204 65 MorthCharles 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2007 IVEY PEARL LOWERY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital ROSE dale
If Under 1 Year | If Under 24 Hrs. Baltimore enter 8. Date of Birth (Month, Day, Year)
Nov. 23, 1912

8. Birthplace (State or Foreign Country)
West Virginia 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F 94 **Director** 220-24-4200 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show at 1 ☐ Yes 2 ☐ XNO notified Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö other traumatic event, the Medical Examiner must be 21237 USA 23a 1321 Spring Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>م</u> 3√2 Widowed 4 □ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Nurse Assistant Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Thomas Franklin Lewis McBride Anna Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 111 Fern Drive, Joppa, MD 21085 Elva O.O. Lowery / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Grdn 11-2-07 Bel Air, Maryland 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initiediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the as 1 attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed?

1 Yes 2 No Division or Vital Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA P After this 28a. Date of Injury (Month, Day Year) 27. Manher of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Hospital or Attending 1 Natural within 24 hours after dearn.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 101 who completed cause of death (Item 23a) (Type, Print) Baltimore MD 2123 Franklin Square Drive 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** hancaster 23 2007 75000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1 sour + soci 10(4)and ecurity Number benera If Under 1 Year | If Under 24 Hrs. 6. Sex, 1 M 2 □ F (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a, State 10b. County ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director altimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Stockton Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Gue Year or Dates: Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1□Yes 2No Baltimore, Maryland 21215-0036 Specify: Completed by Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. PO NOT use retired) Department of Health and Mental Hygiene important: If item 27 is marked other than any injury or other traumatic event, the Meone. Elementary/Secondary (0-12) College (1-4or 5+) Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ္ Mahlan Lancaster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) N. Stockton Street. Bultimore MD 21317 Durnettal -cincaster 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10/30/07 Owings milk, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Vaughn C Green Juneau Scroice Baltimore National Pive 23a. Part1. Entertine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimere, NO 21239 Immediate Cause (Final disease or condition resulting in death) **Physician** Lucamouro HERICATION /Medical Due to (or as a consequence of) Examiner 2515 Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 ☐ Yes accinomo Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Yancytopenio 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

lancoster

State Registrar

DHMH 17 Rev 1/2001

completely

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

540 32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

			1- State State Registrar	of Maryland / De	epartment of Health Certificate of Deat	h and Me th	ental Hygie Reg.	ne 2007	34926			
数	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death				
	/Medic		Nel  4a. Facility Name (If not institution, give street and n	on of Death	Octob	oer 23, 2007 4c. County of Deatl	5:25 a. <sup>™</sup>					
	and the state of t		Howard County (				mbia		loward			
200	Funeral Director		5. Social Security Number 236-48-5343 6. Sex 1 □ M 224 F	7. Age (In yrs. last birtho	Months Dave Hour	der 24 Hrs. 8	B. Date of Birth (Month, Day, You May 5,		nplace (State or Foreign untry) Kentucky			
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits			
	Maryla t-f sho fied al	tor	Maryland Howard	,,	Ellicot	t City			1 □Yes 2 No			
	th with the 23a or 28a ist be not	al Director	10e. Street and Number 2986 Bethany Lane		10f. Zip Code	21042	10g.	. Citizen of What Co. U.	untry? S.A.			
36	be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced Year or	Sive No	<ol> <li>Was Decedent of Hispanic If Yes, specify Cuban, Mexi</li> <li>1 ☐ Yes 2 ☐ No Spec</li> </ol>		ify Yes or No- ican, etc.)	14. Race - Amer Black, White Specify:	e, etc.			
9-19	2 hour natural ical Ex	ted t	15. Decedent's Education	16a. De	ecedent's Usual Occupation		16	b. Kind of Business/I	White ndustry			
1218	within 7 iene.  than "r	Completed	(Specify only highest grade completed Elementary/Secondary (0-12)  College	(1-4or 5+)	Rive kind of work done during n fe. DO NOT use retired) Math Tea		7	Edu	ıcation			
Maryland 21215-0036	be filed valued by the half	Be	17. Father's Name (First, Middle, Last) Rexford Raymond Picl	klesmier			First, Middle, Mai					
aryla	s 1 and 2 should be f f Health and Mental I ftem 27 is marked or other traumatic eve	ဥ	19a. Informant's Name/Relationship (Type. Print)		lailing Address (Street and Nur	mber or Rural	Route Number, C	City or Town, State, Z	lip Code)			
Š,	nd 2 alth a 27 is r tra		Mr. Paul Lopata	Husband	2986 Bethany Lane							
Baltimore,	0 0		20a. Method of Disposition  → Burial 2 □ Cremation 3 □ Removal fror 4 □ Donation 5 □ Other (Specify)	cemetery,	isposition (Name of crematory or other place) and Veterans Ceme	tery 1	te 200 10/29/07	c. Location - City or Garrison For	Fown, State rest, Maryland			
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Parice Densee  22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043									
\$			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Betw.									
	Physician /Medical	Immediate Cause (Final disease or condition resulting in death)  Probable Myocardial Infarction  Due to (or as a consequence of):										
	Examiner	_	Sequentially list conditions, b Ath	Atherosclaratic Cardivascular disease Due to (or as a consequence of):								
	uted d ansit	Examine	Scape fieldy list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	o (or as a consequence or):								
90,	ficate be executed physician and s the burial-transit		resulting in death) Last Due to	o (or as a consequence of):								
68760,	ficate b physic s the b	edical	d									
P.O. Box	death certi e attending d for use a	Physician/Me	in the past 12 months?	gnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of c Month		very Day Year			
ď.	w requires that the de been signed by the s should be detached	by Ph	Part II. Other significant conditions contributing to		e underlying cause given in Pa	art I.	23e. Did tobac	cco use contribute to	the cause of death?			
ord	require een siç hould b		HTN, COPD, Morbid				1 ☐ Yes	2 No 3 Pro	obably 4√□XUnknown			
I Rec	The lar	Completed	Lymphedema, Hyperlipidemia  24a. Was an autopsy finding prior to completion death?  1   Yes   2   No									
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  1   Hospital: Hospital:		Other		Check only one)					
n or \	ing Phys After this uneral dii	on: To	27. Manner of Death 28a. Date	Inpatient 2X ER/Outpa e of Injury 28b. Tim enth, Day Year) Inju	ie of 28c. Injury at	28	e 5 Residence d. Describe how	e 6 □Other (Specinjury occurred	cify)			
Division or Vital Records,	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director, the funeral director director director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place		Location (Street and Number or Rural Route Number, City or Town, State)							
	Hospital 4 hours a Funeral (	Medical Ce	29a. Certifier  (Check only 2   Medical Examiner: On the	basis of examination and/o	eath occurred at the time, date or investigation, in my opinion,	e and place, and death occurred	nd due to the caus	se(s) and manner as	stated. to the cause(s)			
	To the within ?	Mec	one) and ma	inner stated.	29c. License numbe			. Date signed (Month	n, Day, Year)			
	5		Mount		D 00 626	34	10	2/24/2007				
1	0		30. Name and address of person who completed can Matean Awan, MD 10		pe, Print) y Ridge Rd.	C 0 1	ımb i s	MD 21044				
	Sta		31. Date filed (Month, Day, Year) 32.	Agistrar's Signature	A RIGGE RG.	CUTU	umu 1¢,	110 41044				
	Registr	ar	OCT 3 1 2007	College St. 1	1500 CE J							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19<sup>Day</sup> **Physician** Aaron Louden Month 2007 8: 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bon Secour Hospital Baltimore 8. Date of Birth (Month, Day, Year) Feb. 13, 1937 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 213-32-1067 1 X M 2 F 70 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State MD 1 ¥Yes 2 No Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or Items 23a or the Medical Examiner must be 314 North Mount Street 21223 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc 1 ∐ Yes 2XX No If Yes, Give Year or Dates: 1 Never Married 2 Married African American Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ... wrthii
...wental Hygiene.
...z7 is marked other than "v traumatic ever-Elementary/Secondary (0-12) College (1-4or 5+) laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill timent of Health and Mental H tant: If item 27 is marked oth Be Ollie Louden Lillian Toliver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Louden / Brother 231 N. Gilmor Street; Baltimore, Maryland 21223 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State to Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial Park 10/26/2007 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 638 North Gilmor Street; Baltimore, Maryland 21217 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consedience of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-trar and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ed by t signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 1□ Yes 2Z No certificate Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 2 Accident 5 Pending Injury thours after death.

Funeral Director: Af
ely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2128 Willie B.

Registrar DHMH 17 Rev 1/200

State

COV

31. Date filed (Month,

Day, Year)

3

carensulle

Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 200**7 Physician** 6:45 P M Melvin U. Moxley Oct 29 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick North Hampton Manor Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/27/1920 Birthplace (State or Foreign Country) 5. Social Securify Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours XXM 2□ F Director MD 87 <u> 218281060</u> Usual Residence of Decedent the Maryland 10c. City, Town or Location a or 28a-f show t be notified at 10a State 10h County 10d. Inside City Limits 1 □ Yes 2XXNo Director Frederick MD New Windsor 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 15603 Wild Rose Ct. items 23a on the must b 21776 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes A MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes XIX No Specify: White Specify: þ XXWidowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than " ntal Hygiene. ed other than event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Grounds Keeper MD School for Deaf 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental 27 Is marked c Allison Moxley Margaret Shoemaker 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 lt Katie Keilholtz(niece) 449 Consiler Lane Hedgesville, WV 25427 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o once, 1 N Burial 2 □ Cremation 3 □ Removal from State 10/31/2007 4 ☐ Donation 5 ☐ Other (Specify) Locust Grove Cem Mt. Airy, MD Burrier-Queen Funeral Home and Crematory, P.A. 21. Signature of Funeral Sep. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately approximately Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2-3 Day disease or condition resulting in death) Dreumania /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or Injury that initiated avents. Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy perform 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Natural 2 Accident Injury 5 ☐ Pending investigation after death. I Director: A d in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by 4 ☐ Homicide within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical and manner stated. 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Hiren

Thonson

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thoma

31. Date filed (Month, Day,

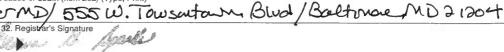
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #788 perFH,0872, 10/31/07 TT Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Mary Concetta Maffezzoli 10 2007 26 7:36 P. /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | / (Month, Day, Year) | 5 / 1 / 1914 | 1943 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** New Jersey Months 64 Director 155-32-5868 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits la or 28a-f sh t be notified Director Maryland Baltimore 1 ☐ Yes 2 No Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country United States Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 1312 Westellen Road 21286 of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status "natural", or item ledical Examiner n Black, White, etc. ☐Yes 2 f Yes, Give 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2/2 No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed er than "natur , the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0,12) College (1-4or 5+) tal Hygiene. +5 St. Vincent's Center Social Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 Is marked traumatic ev Joseph Felcone Mary Cellini P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Dr. Richard D. Maffezzoli/spouse 1312 Westellen Road Towson, Maryland 21286 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or conce, P⊠Burial 2 ☐ Cremation 3 Removal from State November 4 Donation 5 Dother (Specify) Memorial gardens 3, 2007 Timonium, Maryland 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A 21. Signature of Juneral Service Lizense York Road Timonium, Maryland 21093 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician mouth disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) O. Box 68760. Physician/Medical the hh attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknow or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2 No 1☐ Yes 1 Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: HOSPICE 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home Certification: To 6 Other (Specify) this 5 Residence Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred **Division** or Attending 1 Natural 2 Accident 5 Pending investigation Injury after death. I Director: A 1 Tyes 2 □ No the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accurred at the cause (s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

e Funeral Hospital To the within 2

> 31. Date filed (Month, Day, Year) 3 1 ZUU7 Registrar

29b. Signature and title of certifier



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician GEURGE MILLER OCTUBER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) n Hospital 7. Age (In yrs. last birthday) amaritan 5. Social Security Number 9. Birthplace (State or Foreign Country) 6 Sex **Funeral** 1 M M 2 □ F 165-16-015 Yrs. Director May 24, 1919 Philadelphia PA Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits fshow ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 K No Director Parkuille altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hvenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 AYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Marylahd 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Montgomen Elementary/Secondary (0-12) College (1-4or 5+) 12 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev Kaymond J. M. 19a. Informant's Name/Relationship (Type. Print) Elizabeth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Miller - 20a. Method of Disposition Hvenue Parkville Hd 21234 7829 <u>Daniels</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 11-01-2007 Parkville Md

22. Name and Address of Facility
Evans Funeral Chapel + Cremation Services

8800 Harford Road Parkville Md 21234 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee mar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ACUITE MIDLARDIN INFAMEDON Homs /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): TEMS DISLEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CMDIDVISCULM DISCUSE MODIUSCLIMITIC TEMMS Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? POST PULIO SYNDLUME No 3 Probably 4 Unknown 1 🗌 Yes Completed CHMINIC RESPINATORY FAILURE 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of performed? Yes 2 No this certificate death? 1 ☐ Yes 2 ☐ No or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🗙 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation in 24 hours after use the Euneral Director: After Funeral Director: After the Funeral Filled in by the funeral filled in 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

8

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEMAUN N- SWITMD 5601 LOCH

2007

32. Registrar's Signature

31. Date filed (Month, Day, Year)

CCT

D 15135

5601 LOCH RONEN SUD, BANTMUNE, MD 21239

DUNGER 28, 2007

			For State Registrar	State of Ma	aryland	-	artment of F rtificate of I		Mental Hy	giene Reg. N2 ()	07	34931
1	Dhysisi		1. Decedent's Name (First, Middle,	,					2. Date of De	ath		3. Time of Death
	Physici /Medio		ALEXANDER JAMES MCQUEEN OCTOBER 20 2007						12:11 A <sup>M</sup>			
	Examir	er	4a. Facility Name (If not institution, give street and number)  NATIONAL INSTITUTES OF HEALTH  BETHESDA						n	4c. County of E		
h	Funeral	7/10		Sex 7. Age	(In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h		place (State or Foreign ntry)
āc.	Director		255-71-5115	1X M 2□F 18		Yrs.	World Days	Tiodis William	June 6	1989	Geo	rgia
	/land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	e Mar a-f sh tified	ctor	GA Gwinne	tt	Nor	cross						1 ☐ Yes 2 ☑ No
	vith th	Director	10e. Street and Number 459 Pardon Court	Λnt Λ			10f. Zip Code 30092			10g. Citizen	of What Cou	ntry?
	leath v	Funeral	11. Marital Status	12. Was Decedent 8	Ever in U.S.	. 13.1	Was Decedent of H	ispanic Origin? (5	Specify Yes or No		Race - Ameri	can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 ☑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	lo		lf Yes, specify Cuba 1 □ Yes 2 🖾 No	an', Mexican, Puèr Specify:	to Rican, etc.)		Black, White, ec <i>ify:</i> Whi	
5-0036	'2 hou natura ical E)	ted	15. Decedent's	Education		16a. Dece	dent's Usual Occup	ation	rkina	16b. Kind o	f Business/Ir	ndustry
215	ithin 7 ne. han "r e Med	Completed	(Specify only highest : Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work done of NOT use retired	during most or wo	rking	Educa	+100	
2	filed w Hygie ther t	⊙ Co	11th  17. Father's Name (First, Middle, La	st)		Stud	ent	18. Mother's Na	me (First, Middle,			
Maryland 2121	lental rked o	To Be	Steven Browning	•					n Patric			
lary	2 shou and A is man		19a. Informant's Name/Relationship	,	- 1		ng Address (Street					
ک ش	1 and Health Sm 27 ther tr		Jessica Bradley  20a. Method of Disposition	/Sister	20h Pla		Rosy Lar		Centervi Date		A 201 on - City or T	
Baltimore,	ages ent of l nt: If ite		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				sition (Name of matory or other plac tan Crema	1		Alexan	-	
altii	rmit. F partme portar y injur		21. Signature of Funeral Service Lic	•	pricer	22	. Name and Addres	ss of Facility M	arshall'	s Fune	ral Ho	
00	B B E B		JA Mar	shall			217 9th S				, DC	20011
1			23a. Pafyl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death									Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Pa. Due to (or as a	l mone	n w of):	edema					
	Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, that you have been cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Chronic granulon Aus disease  Due to (or as a consequence of):								6 months	
	ed sit	iner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	inonsiquent@fit:							6 months 18 years
	The law requires that the death certificate be executed to has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	<i>OhiC</i> a conseque	onsequence of):						10 gais	
68760,	ate be nysicia he bur	edical		d								
	certific ding pl	/Mec	IF FEMALE:	23c. If yes, outcome	of pregnance	PV.				00.1	D	
Box	death of attent	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at	2 ☐ Fetal d	leath 3	Ectopic pregnancy Other (specify)	′		23d.	Date of deliv Month	ery Day Year
д О	at the de by the tached	hysi	9 Unknown	9□Unknown								
18, 1	w requires that s been signed to should be deta	by	Part II. Other significant conditions	contributing to death bu	ıt not resulti	ing in the u	nderlying cause give	en in Part I.	23e. Did t		ontribute to t o 3 ☐ Pro	the cause of death? bably 4 Unknown
000	w requ	letec							24a. Was	T-		opsy findings available
Vital Hecords,	sician: The law certificate has l irector, page 2 s	Completed							autor perfo	rmed?	prior to co death?	ompletion of cause of 2□ No
Ita		BeC	25. Was case referred to medical examiner?					26. Place of De	1 Yes ath <i>(Check only c</i>		121163	2 110
0	Physic this ca	6	1 Yes 2 No  27. Manner of Death	Hospital: 1 Inpatie		R/Outpatien	t 3 DOA Oth	4 ☐ Nursing I	Home 5 ☐ Resid			fy)
O	th. : After : funer	tion	1 Natural 5 Pending 2 Accident investigat	(Month, Day		Injury	Wor	yai k? Yes 2∐No	28d. Describe	now injury oc	currea	
DIVISION	Hospital or Attending Physician: 4h hours after death. Funeral Director After this certificately filled in by the funeral director, tely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not determine		ry - At hom :. (Specify)	e, farm, str	eet, factory, office	<b>1</b>	28f. Location (3	Street and Nu	ımber or Rui	al Route Number,
ב	urs aft		170-0-11									
	e Hos 24 ho e Fun	Medical	29a. Certifier  (Check only one)  1 ✓ Certifying  2 ☐ Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examinatio	on and/or in	vestigation, in my o	pinion, death occ	e, and due to the urred at the time,	date and pla	ce, and due	stated. to the cause(s)
	To the Hospital or Attendir within 24 hours after death.  To the Funeral Director: At completely filled in by the fu	Me	29b. Signature and title of certifier	) //	$\bigcirc$		29c. Licens			29d. Date sig	gned (Month	Day, Year)
	2		1/1/	-/11				7951		10,	279	2007
			30. Name and address of person wh MILAD POOR				Print) INTER DR	IVE, BI	ETHESDA	, MAR	YLANI	20892
	Sta		31. Date filed (Month) Day Year)	07 32. Registra	- 17	- A	Les .			-		
	Registr	ar	an etc But Entering			-						

State of Maryland / Department of Health and Mental Hygiene 2007 - State Registrar Amend #8, perFH, C873, 11/19/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 6:41 A M Elizabeth Rawson Macgill October 0 29, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 8. Date of Birth 12/22/1918. Birthplace (State or Foreign (Month, Day, Vear) England If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐XF Months Days Hours Director 578-30-9251 88 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits a or 28a-f show be notified at 28a-f show 1 □ Yes 2 □ XNo Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 W. Joppa Road 21204 U.S.A. "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examines 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: 3 XWidowed 4 Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Historian Historical Library 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Norman Rawson Mav Maud Sexton မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Ρ. Jackson Son 132 Laurel Road Arden, North Carolina 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp.: 10-31-2007 Towson Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 tagan 23a. Part1. Enter the disease, or comit cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only of e-cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBAOUAS CULAR 5 MINUTES /Medical Due to (or as a consequence of): Examiner 20 YEARS HYPZRTZNSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine executed burial-tra Due to (or as a consequence of): P.O. Box 68760. attending physician The law requires that the death certificate be Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Division or Vital 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Injury at Work? Certification: 1X Natural 5 Pending investigation 1 Yes 2 No I Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) DO053364 07 11) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10755 FALLS 21093 RS LUTHERVILLE MA and WILLIAM 5. DUETLE

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month,

Day, Year)

OCT3 1

2007

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 1 2007 /Medical 4c. County of Death 4a. Facility Name Af not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 24 Hrs. MORE 5. Social Security Number 210-28-8489 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 M 2 □ F Director Usual Residence of Decedent death with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location r 28a-f show notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or edical Exaπiner must be r 302 USA 14. Race - American Indian, Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armer Forces?

1 Yes 2 No 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Ite 1 Newer Married 2 Married If Yes, Give AFKR 1955 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify Specify: White 3 Widowed 4 □ Divorced the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seçondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 OTTRI 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date City or Town, State Department of H Important: If iter any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Funeral Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** LANCE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and dbe detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No funeral director, page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → No 24a, Was an autopsy performed?
Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Tyes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural Injury 5 Pending death. 1 Yes 2 No investigation 2 Accident **Director:** 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital within 24 hours a 29a. Certifier 1 [Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) MILYARL VINVANC 4940 ILA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

			1 = For State Registrar	State of Maryla	nd / Depa	artment of F	lealth and <i>Death</i>		giene Reg. No		34934
			1. Decedent's Name (First, Middle, La	st)				2. Date of De	ath		3. Time of Death
	Physici /Medi		John Mi	ırrv		Martin		Oct.	25. Day	2007 Year	02:48 M
	Examir		4a. Facility Name (If not institution, giv			4b. City, Town, or	r Location of Dea			County of Death	
			12115 Northwood	Drive		Upper	r Marlbo	ro	Pr	ince Ge	nroe's
Ħ.	Funeral		Social Security Number     6. S	3 1 7	. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	s. 8. Date of Birt	h	9. Birth	place (State or Foreign
	Director		347 14 6743	M 2□F 84	Yrs.	WOTHIS Days	riouis Will	April	11,	1923 I	llinois
	pur *		Usual Residence of Decedent  10a. State 10b. County	10c C	ity, Town or Lo	antion					10d Inside City Units
	sho	5	,	-							10d. Inside City Limits
	the A	Director	Maryland Prince	George's	Upper	Marlboro	0				1 □ Yes 2 □ No
	with					10f. Zip Code 20772				izen of What Cou ited Sta	*
	d within 72 hours after death with the Maryland Jene r than "natural", or items 23a or 28a-1 show the Maxical Examinar must be notified at	Funeral	12115 Northwoo	d Drive	IS 13 1	Was Decedent of H	isnanic Origina (	Spacify Vas or No.	- 7	14. Race - Amer	
<i>'</i>	fter d	F	1 Never Married 2 Married	Armed Forces?		f Yes, specify Cuba	in, Mexican, Pue	rto Rican, etc.)		Black, White	
98	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes XX No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:			Specify: Who	ite
21215-0036	72 ho	Completed	15. Decedent's Ed		16a. Dece	dent's Usual Occup	ation		16b. Ki	ind of Business/li	
21	within 7 ene. than "r	pje	(Specify only highest gra	College (1-4or 5+)	(Give	kind of work done of OO NOT use retired	during most of wi d)	orking			
2	filed with Hygiene. other than	00	Elementary/Secondary (0-12)	2	D	irector o	of Perso	nnel	US	Governm	nent
nd	e = 2 ≥	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	Maiden	Sumame)	
yla	should but nd Ment marked umatic a	2	Arthur Martin					Alice C	olga	an	
Maryland	2 should to and Ment is marked aumatics		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	g Address (Street	and Number or F	Rural Route Numbe	r, City o	r Town, State, Zi	p Code)
	1 and 1 Health tem 27		Christine Marti		121	15 Northw	wood Dri	ve, Upper	r Ma	rlboro,	MD 20772
O			20a. Method of Disposition 1 X Burial 2 Cremation 3			sition (Name of natory or other plac	e)	Date	20c. Lo	cation - City or T	own, State
E	Pages ment of 1 ant: if its ury or o		4 □Donation 5 □Other (Specify	Re	surrect	ion Ceme	tery Oct	31,2007	C1	linton,	MD
Baltimore,	permit. Pages Department of Important: If I sny injury or once.		21. Signature of Juneral San legicen	1/2 11/	U 22	. Name and Addres	ss of Facility	Lee Fune:	ra1	Home, In	nc.
_	40 E # 61		4977102	>) MO190						ad Clint	con, MD 2073
			236. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the dea one cause on each line.	th. Do not ent	er the mode of dyin	g, such as cardia	ac or respiratory ar	rest,		Approximate Interval Between
	Physician		fmmediate Cause (Final disease or condition	4 LOPATO	CEL	LULAR	CARC	-I NOM	1-		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec					•		
	LXamille	_	Caquantially list conditions,	b							
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):						
	and and I-tran	Examin	that initiated events resulting in death) Last	C. Pue to /or on a company							
8760,	ficate be executed physicien and s the burial-transit	E		Due to (or as a consec	(uerice or):						
87	physi the	dical		. d							
×	The law requires that the death certifi ste has been signed by the attending i bage 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregn.	anov						Tr.
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Feta	al death 3 🗆	Ectopic pregnancy			1	23d. Date of deliv Month	ery Day Year
o.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	10a(II 5 _	Other (specify)					
م	that ed by deta		Part fl. Dther significant conditions of	ontributing to death but not res	sulting in the ur	deriving cause give	en in Part I.	23e. Did to	bacco u	se contribute to	the cause of death?
g	uires sign	d by						1 🗆 Y	es 2	No 3□ Pro	babfy 4 □Unknown
Ö	w requir been si should I	Completed						24. 146			
æ	has ge 2	E P						24a. Was a autop perfor	sy	prior to co	opsy findings available ompletion of cause of
ल	ician: Th certificate rector, pag		25 Was some referred to medical					1 Tes	2 No	1 🗆 Yes	2 No
₹	Physician: r this certifica ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	I EDIO	Othe	Nr.	ath (Check only or			
ō	Phy r this aral di	ь,	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐	ER/Outpatient 28b. Time of	3 DOA	4   Nursing	Home Resid		6 ☐ Other (Speci	fy)
٥ ا	ding th. : After s tuner	ţi	1 Natural 5 Pending 2 Accident investigation	28a. Date of fnjury (Month, Day Year)	Infury	28c. Injury Work M 1 🗍	ເ?ົົ ∕es 2.∐No	200. 2000.00 1.	ow injur	y coodings	
Division of Vital Records,	or Attending atter death. Director: After in by the tune	Certification;	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, stre			28f. Location (S	treet an	d Number or Rus	al Route Number,
á	atte Dire	erti	4  Homicide determined	building, etc. (Special	fy)	,,,		City or Tow			
	To the Hospital or Attending Physician: The within 24 hours atter death. To the Funeral Director: After this certilicate he completely tilled in by the funeral director, page		29a. Certifier 1 Certifying Phy	ysician: To the best of my kno	wledge, death	occurred at the tim	e, date and plac	e. and due to the o	ause(s)	and manner as	stated
	18 Hc	edicai	(Check only 2 Medical Examone)	iner: On the basis of examina and manner stated.	ition and/or inv	estigation, in my op	inion, death occ	urred at the time, o	late and	place, and due t	the cause(s)
	To the Hospitai or within 24 hours atte to the Funeral Dir. completely tilled in I	Me	29b. Signature and title of certifier			29c. License	number	-	9d. Dat	e signed (Month,	Day, Year)
	4		1 Grate M			D43	346		10	125/0	1
,	A .		30. Name and address of person who o	completed cause of death (fter	n 23a) (Type, I	Print)				, ,	
1	U		Rita Gupta. MD	8926 Woodyar			inton	Morri and	207	25	
(E)	Sta		31. Date filed (Month, Day, Year)	Mz. Hegistrar's Signi	ture NOdd	# <u>4</u> UI UI	THEON,	rary rand	<del>2U</del> /.	∋∋	
-	Registra	ar	OCT 3 1 200	1 Jan Sian Al	The state of the s	William .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Joan Roberta McMahon 2007 Oct /Medical 2:07 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Hospital Bel Air

If Under 1 Year | If Under 24 Hrs. Harford Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** 1□ M 22 F Days Months Hours Min. 217.40.0687 Director 63 02.21.1944 ΜD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Worcester Pocomoke City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4884 Fleming Mill Road 21851 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ 160 If Yes, Give Year or Dates: 1 ☐ Never Married Married "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed a y injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture p rmit. Pages 1 and 2 sho ld be filed v D partment of Health and Mental Hygie In portant: If item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Robert Teague Doris Lorraine Linaburs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorrie Jarchelski 4417 Cooper Road, Whiteford, MD 21160 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crem. 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 10.27.07 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation And FuneralBalto Ru Alternatives 8717 Green Pastures Dr. Sue 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2010 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and/ Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent prefnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed Yes 2 No the Hospital or Attending Physician: nin 24 hours after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature/and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lesseen Kurtom Upper Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2007 34936 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 **Physician** 1:00 PM BERNICE MATHEWS /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BON SECOURS BALTIMUNE MD HAB3 HOSPUTAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1 M 2CXF MARYLAND Director 86 MAR. 214-18-5122 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10h County or 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director MARYLAND BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23a 4811 CORDELIA AVENUE U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other then "natureli, or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 ☒ X o Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COOK BALTO CITY SCHOOLS 12years 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES H. WHITE RACHEL L. SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4809 Cordelia Ave., Balto, Maryland 21215 Alma Miller/Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete permit. Pages 1 Department of H Important: If ite ony injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) MT ZION CEMETERY 11-6-07 LANSDOWNE, MARYLAND 21. Sign at re of Funeral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) SEP 515 **Physician** /Medical Due to (or as a consequence of): RENAL DISTASE **Examiner** STAGE Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that infrated events resulting in death) Last Due to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 DNo
9 ☐ Unknown Month Dav Year 5 Other (specify) ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ DILATER CARINO MYODATHY; ATRIAL FIBRICIATION 1 Yes 2 No 3 Probably 4 Unknown Completed LETT MASTECTOMY FOR BREAST CA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? RIGHT NEPHRECTOMY FOR RENAL CA 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 27. Menner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Certification: 5 Pending Investigation within 24 hours after death.

To the Funerel Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Janes V. moghelli, mo wir w. Entrimont 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JANET Y. MUGHATELI, MO BALTIMORE, MO 31. Date filed (Month, Day, Year) OCT 3 1 2007 32. Registrar's Signature State Registrar

Phy

Fune

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 7 Reg DHMH 17 Rev

	Please Type or Print in  State of Maryla	and / Depa	rtment of H	ealth and Me	ntal Hygi	ene	
	Registrar	Cer	tificate of L			g. No. 200	7 3493
ian	1. Decedent's Name (First, Middle, Last)  REGINALD Q, MACK				Date of Death Month	Day Yea	3. Time of Death
al er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	Ciubei	4c. County of D	
44	UNION MEMORIAL HOSPITAL		BALTI			N/A	
	1□M 2□E	rs. last birthday) 5 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth JAN 14	Year) 9.1	Birthplace (State or Forei Country)
	215 56 2714 X				72114 • 1	M	D
<u> </u>		City, Town or Lo					10d. Inside City Limit
Director	MD. N/A	BAL	TIMORE				1 ∑Yes 2 □ N
	1639 N. WASHINGTON ST.		10f. Zip Code 212	1.3	10	g. Citizen of What USA	Country?
Funeral	11 Marital Status 12. Was Decedent Ever in	U.S. 13. V	Vas Decedent of His	spanic Orlgin? (Speci n, Mexican, Puerto Ri	fy Yes or No-		merican Indian,
	1 Never Married 2 Married 1 Tyes 2 Married 1 Tyes 2 Married 1 Tyes 2 Married If Yes, Give		f Yes, specify Cubai ☐ Yes 2 <b>X</b> No	n, Mexican, Puerto Ri Specify:	can, etc.)	Black, W	
d by	Year or Dates:					Specify: B	
Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	ent's Usual Occupa kind of work done d OO NOT use retired)	uring most of working	1	6b. Kind of Busine	ss/Industry
omo	Elementary/Secondary (0-12) College (1-4or 5+) 9 TH		BORER			RAILROA	D
BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name (	First, Middle, M.	aiden Surname)	
To	ROBERT D. MACK			MARY	NOXIC		
	19a. Informant's Name/Relationship (Type. Print)			nd Number or Rural I			
	MARY LAWSON (sister)  20a. Method of Disposition 20b					Oc. Location - City	or Town State
	1 ☐ Burial 2 X Cremation 3 ☐ Removal from State		sition (Name of natory or other place JNT CREM		,2007	BALTIMO	
	21 Spinature of Funeral Service Licensee	22	. Name and Address	s of Facility			· ·
	Deinadine Visa	1 20-11	ALVIN B	. SCRUGG: PRESTON		RAL HOM	
	23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	eatl. Do ot ente	er the mode of dying	g, such as cardiac or i	espiratory arres	st,	Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	Airway	obstr	uction			Onset and Death
	Due to (or as a conse		4				-2 -2 - 11
er	if any, leading to immediate Due to (or as a const	-	lass				2 month
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	ge Re	nal Dis	sease			4 years
EX	resulting in death) Last Due to (or as a conse						
	d						
Physician/Medica	IF FEMALE: 23b. Was decedent program 23c. If yes, outcome pf pred	nancy					
iciar	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	etal death 3□	Ectopic pregnancy Other (specify)			23d. Date of o Month	Day Year
hysi	9 Unknown						
by P	Part II. Other significant conditions contributing to death but not re	esulting in the un	derlying cause give	n in Part I.	23e. Did toba	icco use contribute	to the cause of death?
ted					1 ☐ Yes	2 No 3	Probably 4 Unknow
Completed					24a. Was an autopsy	prior 1	autopsy findings availab to completion of cause o
	OF Management and the first					□No 1□Y	? es 2 No
o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2	 ☐ ER/Outpatient	Othor	26. Place of Death (			~ .
0	27. Manner of Death 28a. Date of Injury	28b. Time of	28c. Injury Work	4 LI Nursing Home		ce 6 Other (S) injury occurred	pecify)
atio	1V⊒Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury		es 2 □ No			
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office	28f	Location (Stre City or Town,	et and Number or State)	Rural Route Number,
	20a Carifier 1 Carifuina Bhuaisin Talla Lay	nowlodge deed	accurred -t " "	a data cod et	4 4		
Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my ki 2 Medical Examiner: On the basis of examinary and manner stated.	nation and/or inv	estigation, in my op	e, date and place, and inion, death occurred	a due to the cau at the time, dat	ise(s) and manner te and place, and c	as stated. fue to the cause(s)
Me	29b. Signature and title of certifier		29c. License			d. Date signed (Mo	
			ATQL	+38946	00	ctober 2	7,2007
	30. Name and address of person who completed cause of death (Ite	em 23a) (Type, F	rint)				J 4-0 1
	Vinay Jagadeesha, M.I	), Unio	on Memo	irial Hos	spital,	MD.	
te ar	31. Date filed (Month Day, Year) 32 Registrar's Sign	nature		irial Hos	epital,	MD.	

	Sex 7. A 1 1	Age (In yrs. last birtl 69 Y	hday) If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, Date   8–12–1	Day, Year)	9. Bi	irthplace (State Country)	te or Foreign
cedent		140 -									100
b. County		10c. City, Town									City Limits
Baltim	ore	Winds	or Mill	-							es 🎘 No
Road			10f. Zip 21	p Code 244					izen of What C	Country?	
2 Married	12. Was Deceden Armed Forces 1 ☐ Yes 2∑ If Yes, Give Year or Dates	s? ] No	13. Was Dece If Yes, spe	ecify Cuba	ispanic Origin, Mexican	gin? (Spe , Puerto l	ecify Yes or No Rican, etc.)	lo-	14. Race - Am Black, Wh Specify Car		
Decedent's E	Education rade completed)	16a. I	 Decedent's Usu <i>(Give kind of wo</i> <i>life. DO NOT u</i>	al Occupa ork done d se retired	ation <i>luring most</i> ')	of worki	ng	1	ind of Business	s/Industry	
ry (0-12)	College (1-4or	r5+)	iver					Longs	shoreman		
t, Middle, Las	st)					r's Name Davis	(First, Middle				
Relationship			Mailing Address						r Town, State,	Zip Code)	
ckenzie,	, WILC	20b. Place of	Disposition (Na	me of	-		Date		ocation - City o	r Town, State	
emation 3   Other ( <i>Spec</i>	**	cemeter	y, crematory or o emorial P	other place ark	1	11-2-(	07	Woodl	lawn, MD		
Service Lice	W W.	( )den	22. Name at 9200 Lib						f Baltim 133	ore Coun	ty
sease, or con	mplications that cause	ed the death. Do no								Approxin	nate
ilure. List onl	y one cause on each	STAGE							ICEAR	Interval E	Between nd Death
	d			_ , v i'	1	1 1 1	· E 14	-1 V	1/4/17)	5	180
-		as a consequence o	1 A A	-921	)1 A	R T	DISE	ACE	2		f
ons,	b	PHEKHI as a consequence o				1	-176	- / ٤	_		
diate g v		as a consequence of	*	0=	-	HO	OAT	•			48.
ry 📄	C		f)·							1	10.
	Due to (or a	as a consequence o	h) 1	TH	t m	(A)	NUT	RIT	10N		
	_d		, - 1	. 1			- 1	- •	. 4	-	
egnant nths?		2 Fetal death at time of death	3 □Ectopic p 5 □ Other (s <sub>i</sub>					4	23d. Date of do	elivery Day	Year
	contributing to death	but not resulting in					23e. Did	tobacco u	use contribute	to the cause of	of death?
- 2		SETES					1 🗆	] Yes 2]	<b>Х</b> Ио З□ F	orobably 4	□Unknown
TH	NEURO	HTAGO	Y med	NE	PHP	DPA					
			•			-117	auto	is an opsy formed?	prior to	autopsy finding o completion o	of cause of
	O AMC	F CO	OLON	V			perf 1□ Yes	formed? 2/X/No	death? 1 ☐ Ye		
to medical	Hear 9					of Death	(Check only	one)			
	Hospital: 1 ☐ Inpat				4 LINU	rsing Hor	me 5X Res	sidence	6 □Other (Sp	ecify)	
□ <b>□</b> □ □ □	28a. Date of In (Month, D		ime of	28c. Injury Work	y at		28d. Describe				
☐ Pending investigation	on	, In	M M		k? Yes 2 ∐ t	No					
Could not determined	be 28e. Place of in	injury - At home, far etc. <i>(Specify)</i>	m, street, factor				28f. Location City or To	(Street an own, State	nd Number or F	Rural Route N	lumber,
	Physician: To the bes	of examination and									se(s)
of certifi-	and manner s	0 1	100	c. License	a Unimpo-			204 5	e signed (**	nth. Day 16	r)
of certifier	orned	lit, m	<b>&gt;</b> .   29	DIC	630	6		[ O	te signed (Mor	O 7	
	o completed cause of	f death (Item 23a) (T	Type, Print)	TIP.	NOR	E	2 m s	>	212	36	
Day, Year) -		strar's Signature	Consider				,				
312	UUI JUST	15° A	-0.00								
		V	ORIGINAL	1							

7:58A. M

State Registrar

ical

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

9125 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELAIR

DHMH 17 Rev 1/2001

07-08205 David Sean Mason Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 34939

VIU Seall Mas	1	- For State	State of Many	Certi	ficate of	Death				eg. No.		10	True of Doodh
Physicia	in/	Registrar  1. Decedent's Name (First, Middle, Last)  Deviid Sean Mason  2. Date of Death Month Day Year October 21, 2007  1800 hrs											
Exami	ner	David Sean Mason			I	b. City, Town, or	Location of		October 2		County of	Death	
		4a. Facility Name (if not institu Northwest Hospital	ition, give street and r	iumber)	"	Randalistov					altimore		•
	-	5, Social Security Number	6. Sex	7. Age (In yrs. last	t birthday)	If Under 1 Yea	If Under	24Hrs.	8. Date of Bi	rth(MM/I	DD/YYYY)	9. Birthp Foreign	lace (State or
Funeral Director		557-03 <b>-</b> 7817	1 X M 2 F	1	Yrs.	Months Day	Hours	Min.	5-31 <b>-</b> 1	002		Count	ry) SC
Directo.	-	Usual Residence of Decedent	2.1	19						7.63			O . I
áu.	ŀ	10a. State 10b. Coun		10c. City, T	own or Locati	on							0d. Inside City Limits  Yes 2 X No
nd how :	٦	MD Ba	ltimore	Wi	indsor M	ill					6100		
arylar 8a-f s	Director	10e. Street and Number	TO THE PARTY OF TH			10f. Zip Code			ļ		zen of Wh	at Country	y :
the M		2400 Battersea	Place, Apt. :	104		21244			'' Man 17 A		ISA 14 Baco	- America	n Indian, Black,
death with the Maryland or items 23s or 28a-f show any must be notified at once.	eral	11. Marital Status		ecedent Ever in U.S Forces?	. 13. Wa	s Decedent of Hi es, specify Cuba	spanic Orig n, Mexican,	in? (Spe Puerto F	Rican, etc.)	iO-	White	e, etc.	
death or ite	Funeral	1 X Never Married 2	Divorced If Yes, Give	2 1 No	1	Yes 2 X No	specify:				Specify:	ican-a	merican
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner	2	3 Widowed 4 15. Decedent's Education (	or Dates:		16a Deceden	it's Usual Occupa	tion (Give	kind of w	ork done	16b.	Kind of Bu	siness/Ind	dustry
hour "natu	Completed	Elementary/Secondary (0-		(1-4 or 5+)	during m	nost of working life	e, DO NOT	use retir	ed)	Ral	ltimor	- Cour	ty Piblic
)36 hin 7, e. than	gu	4th		ļ	Stud	ent							ity Public
5-0C ed wir lygier other the M	Cor	17. Father's Name (First, Mic	idle, Last)						(First, Middle	e, Maider	1 Sumame	,	
21215-0036  July be filed within 72 hours after the Mental Hygies within the Mental Hygies with the marked other than "matural"; or event, the Medical Examiner.	Be	David L. Mason			10h Mailin	g Address (Stre	et and Nur	nber or F	Graham Rural Route N	umber, (	City or Tow	n, State,	Zip Code)
2 2 should nd Mu is ma	2	19a. Informant's Name/Relat				attersea 1							
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and henlal Hygienet. teanth and Menlal Hygienet. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition			lace of Dispo	sition (Name of c	emetery,		Date	20c	. Location	- City or T	own, State
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thin higherly or other traumatic event, the Medi	1	1 X Burial 2 Cremi		ai from State	rematory or o			10-2	7-07	W	oodlaw	a. MD	
t. Pag		4 Donation 5 Other 21. Signature of Funeral Ser	er Specify:	( ) max	• 22.	metery Name and Addre	ss of Facilit	y Wy L	ie F/ H	P.A.	of Ba	ltimor	e County
Balti permit. Departi Import	-	TOGALAR	14 100	(elle	10 192	00 Libert	v Rd.	Rand	allstown	n. MD	21133		
hysician		266. Part I. Enter the diseas	e, or complications th	at caused the death.	Do not enter	the mode of dyin	g, such as	cardiac c	r respiratory	arrest, sl with	hock, or he	eart	Approximate Interv Between Onset ar
/ledical	1	failure. List only one ca Immediate Cause (Final dis	<sub>ease a.</sub> biven	tricular hy	pertroph	ny and rig	nt vent	ricu	lar diĺa	tatio	on		Death
_xaminer		or condition resulting in dea	th) Due to (or a	as a consequence of	f):								
		Sequentially list conditions,		as a consequence of	f):								
	nine	if any, leading to immediate cause. Enter Underlying Ca (Disease or injury that initia	ause c.										
d d	Examiner	events resulting in death) L		as a consequence o	f):								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this careful has been signed by the attending physician and To the Funeral Director. At Grazal director name? should be detached for use as the burial - transit.	la B		d	EO er and	07/ 12	le ka ma							
60, ate be e: shysician	Medical	IF FEMALE:	#2.5a	,27,penth,g	nancy					:	23d. Date		
876 tificat ng phr	}		nt in the 1 L	ive birth	2	Fetal death	3 Ector	oic pregn	ancy		Month	Ε	Day Year
Box 687  e death certific  the attending ped for use as the	Sicial	1 Yes 2 No 9	1 11-1	regnant at time of de Inknown	eath 5	Other (Specify)	-						
P.O. Box 687 that the death certificate order the attending ned by the attending detached for use as the second contract of the second contract of the second for use as the second contract of the second con	Physician/	Part II. Other significant c			resulting in the	e underlying caus	e given in	Part I.					the cause of death?
P.O.									1 🗆	Yes 2	<b>✓</b> No	3 Prol	bably 4 Unknow
duires quires en sig	E P									Vas an utopsy	241	. Were at	utopsy findings availa completion of cause
SOFC law re									'   p	erformed es 2		death?	
tal Rection: The left	Completed by					26.P	ace of Dea	th (Chec		63 2			
ital ician: s certifi	E E		Hospital:	Inpatient 2 ✓	ER/Outpatie	ent 3 DOA	Other <sub>4</sub>	Nurs	sing Home 5	Res	sidence 6	Othe	er:
Division of Vital Records, P.O. talor stending Physician: The law requires that the safter death.  The safter death.  The safter death of the serificate has been signed by the safter the safter of the safter safter the safter	Tuneral director, page z stodio	27 Manner of Death	28a.	Date of Injury	28b. Time o	of Injury 28c.	Injury at W		28d. Desc	ribe how	injury occ	urred	
onding th.		1 X Natural 5	Pending	Month, Day, Year)	Ur	1	Yes 2	No	200			_	
isic Atte	by the	2 Accident 3 Suicide 6	Investigation 28e.	Place of Injury - At I	home, farm, s	treet, factory, offi	ce building	, etc.	28f. Locat or To	ion (Stre wn, State	et and <b>N</b> ur e)	mber or R	ural Route Number,
Div	filled in by the rune	Suicide 6 L	determined (Sp.	ecify)				_	1	-			
Hosp 24 ho Fune			ving Physician: To the	e best of my knowle	dge, death oc	curred at the time	e, date and nion, death	place, a occurre	nd due to the d at the time,	cause(s date and	i) and man d place, an	ner as sta d due to t	itea. he cause(s)
Divisior To the Hospital or Attent within 24 hours after death To the Funeral Director	completely fulled in by the	: I	and mai	nner stated.	and/or mivest		ense numb			2	9d. Date s	igned (M	onth, Day, Year)
	1 2	29b. Signature and title of	certifier	10 0 3		<b>I</b>	.C.M.E.				October	22, 200	)7
1.0	+	n	1 200,	700 9	m 230\								
PAN	W	30. Name and address of Ling Li, MD As	Ferson who complete ssistant Medical	d cause of death (Ite Examiner 11	กก 258) 1 Penn St	reet, Baltimo	re, MD 2	1201					
Joe Jok	Sta			32. egistrar's Signa		1 4							
Reg	gistra	THE PROPERTY OF THE PROPERTY O	3 1 2007	Basine.	13.	2045							
DHMH 17 Rev	1/200	1	OCME		ORIĞI	NAL							

			1 - For State Registrar	State of Ma		/ Depar	tment of	Health and find the second of	-		7007	34940
	Physic /Med		Decedent's Name (First, Middle, La     WILLIAM ROBER						2. Date of D Month Octob	Day	, 2007	3. Time of Death 7:45 A
	Exami		4a. Facility Name (If not institution, gir	· ·		4	b. City, Town	n, or Location of De			County of Death	
			909 Greenway C  5. Social Security Number 6.		a (la usa laa		Havre	de Grace	re   0 = 1 / 2		arford	
	Funeral Director			1 <b>X</b> M 2 □ F	e (In yrs. Ias 65		Months Day			ay, Year)	1 Mary	nplace (State or Foreign untry) Land
	nyland how		10a. State 10b. County		10c. City, 7	Town or Local	tion					10d. Inside City Limits
Son	death with the Maryland ms 23a or 28a-1 show	Funeral Directo	Maryland Harford 10e. Street and Number		Havr	e de C	race 10f. Zip Code	ə		10g. Citiz	en of What Cou	1 ☐ Yes 🏖 No untry?
S	ath w	le	909 Greenway Ct				2107			USA		
21	5 £ 1	þ	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ∑Yes 2 ☐ N If Yes, Give Year or Dates:			s Decedento es, specify C ]Yes 2 1 1 2 1 1 1	of Hispanic Origin? uban, Mexican, Pue lo <i>Specify</i> :	Specify Yes or N into Rican, etc.)		4. Race - Amer Black, White Specify:	, etc.
1am Ne	hin 72 hoi	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5		16a. Deceden (Give kir. life. DO	it's Usual Occ d of work do NOT use ret	cupation ne during most of w ired)	orking	16b. Kin	d of Business/li	hite ndustry
21.	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	Com	12			Owner/	Operat	or		Auto	motive	Machine Sho
7	be file d oth	Be	17. Father's Name (First, Middle, Last	1)					ame (First, Middle			
arm	should be and Mental in marked o	J.	(Unknown) 19a. Informant's Name/Relationship	(Time Print)		40h M-11		Arthur		ichar		
7 5	nd 2 sho lith and 27 is m		Nancy L. Nelson					et and Number or N Ct., Hav				
<u> </u>	s 1 and 3 f Health Itom 27 other tr		20a. Method of Disposition	/ WITE	20b. Plac	e of Dispositi	on (Name of	T.	Date G		ation - City or T	
	Pages ient of int: If ii		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci.			Nin Mo		Gran 10	-30-07	Pol :	Air, Ma	bac Irre
<b>&gt;</b>	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Lice	Husly		22 N MC	Coma S	funeral i	Home, P.	Α.	The Assets	and 21009
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin	the death. I				ac or respiratory			Approximate Interval Between Onset and Death
3	/Medical Examiner			Due to (or as a	consequen	nce of):						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	a consequen	nce of):						
1760	ite be executed ysicien and ne burial-transit	Ical Exa	resulting in death) Last	Due to (or as a	consequen	ice of):						
68	ing ph		IF FEMALE:									
P.O. Box 68	Physician: The law requires that the death certifical this certificale has been signed by the attending primal director, page 2 should be detached for use as it.	by Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 Fetal de	ath 3□Ec	topic pregnar ther (specify)			23	3d. Date of deliv Month	very Day Year
ds. P	signed by		Part II. Other significant conditions of	contributing to death bu	t not resultin	ng in the unde	rlying cause (	given in Part I.		tobacco use		the cause of death?
Ö	w requir been si should	lete							24a. Was			
tal Re	ician: The law certificate has rector, page 2 :	Completed	25. Was case referred to medical						auto perf 1 ☐ Yes	2 No	prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No
Ž	ysician: is certific director.	To Be	examiner?	Hospital:	nt 2 ER/	/Outpatient	3□ DOA C	)than	eath <i>Check</i> only Home 5 2 es.		Other (Case	4.1
Division of Vital Becords.	e e e	atlon; T	27. Manual of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	/ 28	b. Time of Injury	28c. In		28d. Describe			<u>y)</u>
Divis	tal or Atters after de al Directo	Certification;	3 Suicide 6 Could not b determined		ry - At home . (Specify)	, farm, street,	factory, offic	ө	28f. Location ( City or To	Street and wn, State)	Number or Run	al Route Number,
	To the Hospital or Attendia within 24 hours atter death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of niner: On the basis of and manner stat	examination	dge, death oc and/or invest	curred at the igation, in my	time, date and place opinion, death occ	e, and due to the surred at the time,	cause(s) a date and p	nd manner as s place, and due t	itated. o the cause(s)
	To T Com	×	29b. Signature and title of certifier	Elw	ans	-MI	29c. Lice	nse number	5		signed (Month,	Day, Year) 27, 2001
1	54		30. Name and advess of person who	completed cause of de	ath (Item 23	a) (Type, Prir	nt) Til	FAUST	ON M	Cort.	ZLANS	21047
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Asset	200		- 1	0		

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

501

Year)

U299

32. Registrar's

rital

		1 - For State Registrar		State o	f Marylar	nd / De		ent of H	Health a	nd Me	ental Hy	/gien Reg. N	e	0.7	34	94
Physicia /Medica Examine	al	1. Decedent's Name (First, I)  Grace Caroly  4a. Facility Name (If not instited the state of the	n Oi tution, gir	clansky ve street and nui	mber).	3	4b. Ci	-	or Location of	Death	2. Date of Di Month Octob	per	c. County	of Death	3. Time of 10:15	p M
Funeral Director		5. Social Security Number  111-16-9565  Usual Residence of Deceder		Sex 1□M 2【《F	7. Age (In yrs. <b>82</b>		Month	der 1 Year ns Days	If Under 2	4 Hrs. 8 Min.	B. Date of Bi (Month, Di 02/	rth <i>ay</i> , Ye <i>ar</i> <b>14/1</b>		9. Birth Cou <b>NY</b>	place (State intry)	or Foreig
with the Maryland a or 28a-f show be notified at	ctor	10a. State 10b. Co	unty	mery		ity, Town o	da		-						10d. Inside C	,
ufter death	by Funeral Director	10e. Street and Number  4400 East We  11. Marital Status  1 Never Married 2	Married	12. Was Dece Armed Fo 1  Yes If Yes, Giv	edent Ever in Lorces? 2 🔀 Nove	J.S.	13. Was Dec	Zip Code 20814  cedent of Fecify Cub	lispanic Origi an, Mexican,	in? (Spec Puerto Ri	ify Yes or No ican, etc.)	Ur		Sta e - Ameri k, White,	can Indian,	
within 72 hours ene. than "natural" he Medical Ex	Completed b	3 ☑ Widowed 4 ☐ Divo 15. Dec (Specify only hand) Elementary/Secondary (0-	edent's E ighest gr	Year or Diducation ade completed)  College (1		- "		work done use retire			,		Kind of Bu	w II I usiness/Ir	ndustry	
2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Me	To Be Co	17. Father's Name (First, Mic Lawrence Che	ster	Suydam					18. Mother	s Name (	First, Middle	th E	nglis	h		
1 and 2 sho Health and em 27 is m wher traum		19a. Informant's Name/Rela  Susan Orlans  20a. Method of Disposition			205	27	708 W.	64th	and Number	Anch	orage	, AK	995	02-		
permit. Pages Department of I Important: If Ik any injury or o		1 ☐ Burial 2 ☑ Cremat 4 ☐ Donation 5 ☐ Othe  21. Signature of Funeral-Ser	er ( <i>Speci</i>	fy)	State	nespe	isposition (A crematory o	remat	1		ct 24 007			-	own, State Le, MD	
Physician /Medical Examiner  per price pri	ical Ex	23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cisease or injury that initiated events resulting in death) Last	e, or com List only	a. A C C Due to ( b. Due to ( c. Due to (	or as a consection or as a conse	quence of):	enter the m	ode of dyl	ral & Ave., ng, such as co LEU	Silve ardiac or	er Spr respiratory a	ing	, MD	209	Approxima Interval Be Onset and 2 We	Death
is that the death certificated by the attending physical detached for use as the	Pnysician/Med	23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown			irth 2 Feta ant at time of c	al death	3 ☐ Ectopic 5 ☐ Other (		′				23d. Dat Mor		-	Year
w requires that been signed been signed be det	2	Part II. Other significant con		contributing to de	ath but not res	ulting in th	e underlying	cause giv	en in Part I.		10	Yes 2	No	3 ☐ Prol	he cause of d	Unknow
sician: The law certificate has birector, page 2 s	e Completed	25. Was case referred to me	dical						26. Place o	of Death (	24a. Was auto perfo	psy ormed? 2 🔀 No	p	Vere auto rior to co leath? Yes	opsy findings impletion of c	availabl ause of
r Attending ter death. irector: Afte	0	3 Suicide 6 □ Co	nding estigation uld not be termined	28a. Date of (Montal) 28e. Place	npatient 2 of Injury h, Day Year) of injury - At hong, etc. (Specif	28b. Tim Inju	e of ry M	28c. Injur Wor 1 🗆	er: 4 □ Nurs	ing Home	5 🗷 Resi	dence how inju	ry occurre	ed	fy) al Route Nun	nber,
To the Hospital of within 24 hours af To the Funeral D completely filled in		29a. Certifier (Check only one)	ifying Ph ical Exar	ysician: To the niner: On the ba and mann	asis of examina	owledge, dation and/o	eath occurre	ed at the tir	ne, date and pinion, death	place, an	d due to the at the time,	cause(s	and ma	nner as s	stated. o the cause(s	5)
To th within To th comp	-	29b. Signature and title of cel	rtifier	Wdy		Ŧ	2	9c. Licens	e number	7.		29d. Da	ite signed	(Month,	Day, Year)	
20		30. Name and address of per	son who	completed cause	of death (Item	23a) (Ty)	pe, Print) K	KENS	SINGT	GTG	men	no	el do	Ce Lo E	~ KY	
State Registrar	9	31. Date filed (Month, Day, You OCT 3 1	200	32. Re	egistrar's Signa	ture	rate p									

			For 1 _ State	State of Ma	ryland /		rtment of H		d Mental Hyg		2007	21.01.0
			Registrar  1. Decedent's Name (First, Middle,	Last)		0071	inicate of i	Jeann	2. Date of Dea		.001	3. Time of Death
	Physici /Medio		Howard 0.	0den	Jr.				October		2007	12:50 P™
7	Examir	ner	4a. Facility Name (If not institution, 9 8414 Garland Ro				4b. City, Town, or	Location of D asadena			ounty of Death ne Arun	ide]
	Funeral Director		5. Social Security Number 6 215 – 34 – 7400	5. Sex 7. Age 1	(In yrs. last bi	irthday)_ Yrs.	If Under 1 Year Months Days	If Under 24		)	9 Birthn	lace (State or Foreign try)
9	ס		Usual Residence of Decedent					1	0000	1 155		
	larylar show	Į.	10a. State 10b. County Maryland Anne	Arundel	10c. City, Tov	vn or Loc		asadena			1	0d. Inside City Limits 1 ☐ Yes 2 💢 No
	r 28a-f	irect	10e. Street and Number	TH GIIGET			10f. Zip Code	usudend		I0g. Citizer	n of What Coun	try?
	23a o ust be	ralD	8414 Garland Roa	ad				21122	2		US	A
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Inportants: If item 27 is marked other than "natural", or Items 23a or 28a-f show any follury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? d 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:			/as Decedent of H Yes, specify Cuba ☐ Yes 2 ☐ No	ispanic Origin' an, Mexican, P Specify:	? (Specity Yes or No- uerto Rican, etc.)		Black, White, becify: White	etc.
5	72 hor	eted	15. Decedent's (Specify only highest		16a	a. Decede	ent's Usual Occup ind of work done o O NOT use retired	ation during most of	working	16b. Kind	of Business/Inc	lustry
7	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		o <i>not use retired</i> Fire Figl				Fire De	partment
2	e filed al Hygi other vent, t	Be	17. Father's Name (First, Middle, La	ast)			170 1191		Name (First, Middle,			par cheric
<u> </u>	ould by Menta arked	10		Oden Sr.				Mary		Sween		
200	and 2 should salth and Mer n 27 is marke er traumatic		19a. Informant's Name/Relationship Beverly Oden	(Type. Print) (SDOUSE)	I				r Rural Route Numbe Pasadena,			Code)
נ	s 1 an of Heal item 2 other		20a. Method of Disposition	· · · · · ·	20b. Place of	of Dispos	ition (Name of atory or other place		ov. 03		tion - City or To	wn, State
	Pages ment of ant; If ite ury or o		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			-	n Cemeter		I	Glen	Burnie	, Maryland
Dall	permit. Departn Importa any Inju		21. Signature of Funeral Service Li	Hallen	n			ntain R	Stallings Load, Pasac	Fine Jena,	eral Ho	me, P.A.
		e w	23a. Part1. Enter the disease, or or shock, or heart failure. List or	omplications that caused nly one cause on each lin	the death. Do	not ente	r the mode of dyin	g, such as car	rdiac or respiratory arr	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	5//	(	6(1	Lung	Con	Cei-		
	Examiner			Due to (or as a		701	re	10	Civer			18 months
	sit sq	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	. of).						<u> </u>
_	xecute and al-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a consequence	of):						
	icate be executed physician and s the burial-transit			d								
00	entifical ing phy e as th	Medi	IF FEMALE:							1		
.0.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 🗆 Fetal deat		Ectopic pregnancy Other (s <i>pecify</i> )			230	d. Date of delive Month	ery Day Year
ů,	ss that gned b	by Pt	Part II. Other significant condition		_		· /> /		23e. Did to	bacco use	contribute to th	ne cause of death?
200	require een siç rould b	ted t	(6001C	0556-	c//26		.Fula	20019	120	es 2 🗆 l	No 3□ Prob	ably 4 □Unknown
שבו וונ	: The law cate has b page 2 sh	Completed	2050	) <del>(</del>					24a. Was a autop: perfor	sv	prior to cor death?	psy findings available npletion of cause of 2 ☐ No
A .	sician certifi irector	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatier	nt 2 ER/O	utnationt	3 □ DOA Othe	or.	Death (Check only or		Tou 10 11	
5	ig Phy ter this neral d	n: To	27. Manner of Leath	28a. Date of Injur (Month, Day	y 28b.	Time of Injury	28c. Injur	4 ☐ Nursir	28d. Describe h		Other (Specify	<u>"</u>
2	tendin eath. tor: Af the fur	catio	Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	tion			M 1□	Yes 2 □ No				
2	tal or Atres after de al Direct led in by	Certification:	3 Suicide 6 Could not 4 Homicide determine		ry - At home, fa . (Specify)	arm, stre	et, factory, office		28f. Location (S City or Tow	treet and N n, State)	Number or Rura	l Route Number,
	the Hospi in 24 hou the Funei ipletely fil	Medical	(Check only 2 Medical Ex	Physician: To the best o maminer: On the basis of and manner state	examination a	je, death nd/or inve	estigation, in my o	pinion, death	place, and due to the coccurred at the time, o	ause(s) ar date and pl	nd manner as st lace, and due to	ated. the cause(s)
	To To Con	2	29b. Signature and title of certifier	Dorbete	5 0	0	29c. License		C	end. Date s	signed (Month, 2	3 or 7
	iotl			OT- 01.0	eath (Item 23a)	(Type, P	uspila	al Dr.	se Gle	L Be	rnie k	2007
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 3 1 2	2007 32 Registra	r's Signature	Gran	A STATE OF THE STA					
HC	/H 17 Rev 1/26	001				ii .						

07-08250	
Michael Porter	

State of Maryland / Department of Health and Mental Hygiene 2007 34944 1- For State Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Medical Examiner 1443 hrs October 23, 2007 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death Northwest Hospital Randallstown **Baltimore County** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director mD 216 04 4578 1970 1 X M 2 F Country) Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. Count 10c. City, Town or Location Yes 2 No with the Maryland **Funeral Director** 10g. Citizen of What Country? 10e, Street and Number 11. Marital Status Was Decedent Ever in U 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Pages 1 and 2 should be filed within 72 hours after death vient of Health and Mental Hygiene.
ant: If item 27, is marked other than "natural", or item or other tranmatic event, the Medical Eximiner must be or other tranmatic event, the Medical Eximiner must be 2 X Married White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Yes Specify: Black If Yes, Give Year Yes 2 No specify: Widowed 4 Divorced <u>≨</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore. MD 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James atherine **Porter** ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) hulisa 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City of crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Baltimore, mD 10 30 Donation 5 Other Specify: reche Funeral SRVC 21. Signature of Funeral Service Licenses 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interva **Physician** Between Onset and /Medical a. Myocardial infarction Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Atherosclerotic cardiovascular disease Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED attending physician a <sup>AMENDED</sup>b,27,perME,g873, 11/5/07 TI Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (Specify) has been signed by the att 2 should be detached for 1 Yes 2 No 9 Unknown q Unknown P.O. I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Yes 2 ✓ No 3 Probably 4 Unknown Completed Division of Vital Records. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate h ✔ Yes 2 No 1 🗸 Yes No 25. Was case referred to medical 26.Place of Death (Check only one Be Hospital: Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural neral Director: / filled in by the fi 1 Yes 2 No 24 hours after death. Funeral Director: Pending 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 2 To the F 2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 24, 2007 of person who completed cause of death (Item 23a) 30. Name and addre **OCME** Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Mary G. Ripple MD. 31. Date filed (Month, Day, Year) 32@Registrar's Signature State Registra

se Type or Print in Black Indenbie IIII. 2007 amend it em 17 per Department of Health and Mental Hygiene Certificate of Death Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Marilyn Peggy Pelliccia 28, Oct. 2007 6:25P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore Birthplace (State or Foreign Country) If Under 24 Hrs **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 M 2 F Hours Director 073.34.0473 10.07.1943 NY Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 □Yes 2 No Carroll Hampstead 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 3997 Terrace Drive Funeral 21074 S.A. 14. Race - American Indian 12. Was Decedent Ever in U.S.
Armed Forces?

1 E Yes 2 D No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced "natural", White Completed Pages 1 and 2 should be filed within 72 homent of Health and Mental Hygiene.
ant; If Item 27 Is marked other than "natulury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Outler Harry <del>Gutlet</del> Esther Koslin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ralph Pelliccia/husband 3031 Inhertance Road Conway, SC 29527 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State Department (Important; If any injury or Chesapeake Crem. 10.30.07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licenses Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HUNTINATON'S Physician disease or condition resulting in death) YEARS /Medical Due to (or as a construence of): **Examiner** Sequentially list conditions, if any the list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical use as been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☑No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown SCHIZOPHRENIA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Was a... autopsy performed? Yes 2 No CHRONIC OBSTRUCTURE PHIMONARY 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 No ို After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Płace of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide the Hospital 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certific 29c, License number 29d. Date signed (Month, Day, Year) 164395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBERMAN. MO 6565 N CHARLES ST, SUITE 209 BALTIMPLE, MD 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of I	Maryland /		artment o			and M		giene Reg. No 20	17	31,946
*	Physic		Decedent's Name (First, Mid		san Lee I						Date of Dea     Month	ath Day	/ear	3. Time of Death 8:36 p. M
The state of	/Medi Examir		4a. Facility Name (If not institute		er)		4b. City, To	wn, or L	_ocation o		umbia	4c. County of	Death	oward
1	Funeral Director		5. Social Security Number 220-60-2844	6. Sex 1  M 2 A F 7.	Age (In yrs. last t	birthday) Yrs.	If Under 1 Y Months D	/ear lays	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Novemb	h y, Year) eer 17, 1951	). Birthp Cour <b>Wa</b>	place (State or Foreign htry) shington , D.C.
	aryland show ed at	ž	Usual Residence of Decedent  10a. State 10b. Count  Maryland	ty Howard	10c. City, To	wn or Lo	cation		Columb	ia			1	0d. Inside City Limits
	with the N a or 28a-f be notiffe	Director	10e. Street and Number 9922 Ferndale				10f. Zip Co			045		10g. Citizen of Wh		1 □ Yes 2 No
9	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Ma	12. Was Decede Armed Force	s <b>7</b>		Was Decedent If Yes, specify		panic Oric , Mexican		cify Yes or No- Rican, etc.)	. 14. Race - Black,		ean Indian,
Maryland 21215-0036	n 72 hours "natural"; edical Exa	Completed by	(Specify only high	ed Year or Date: ent's Education lest grade completed)		a. Deced	dent's Usual O kind of work a	ccupati	Specify: ion iring most	of workin	ng	Specify:	ness/In	White
Z1Z p	filed withi Hygiene. ther than	Comp	Elementary/Secondary (0-12)  17. Father's Name (First, Middle	3-4	or 5+)	me. L		raleg	gal Spe	ecialst		Moidon Curro ma		aw
rylan	hould be of Mental marked of matic eve	To Be		Richard Carver	46	No. Ad - No.							wx	40000
2	ges 1 and 2 should it of Health and Men If Item 27 is marke or other traumatic		Mr. Philip						Ave C			r, City or Town, St nd 21045		
baltimore,	t. Pages tment of I tant: If Ite		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (	(Specify)		ery, cren Ba	sition (Name of natory or other ayview Cr	r place) emat	ory		10/31/07	20c. Location - Ci	-	ovn, State ore, MD
ga	permit. Pag Department Important: any Injury o		21. Signature of Funeral Service	Milisturi	YN01293		. Name and A Sla 38	71 OI	ld Colu	ımbia	Pike Ellico	tt City, MD 2	1043	
學	Physician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	_a.Met	ed the death. Do	te	er the mode of	by by	such as c	sardiac of	respiratory and	rest,	- 5	Approximate Interval Between Onset and Death 22
,0070	cate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>1</b> c	as a consequence									
O. BOX 00	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal deat at time of death		Ectopic pregn Other (specif					23d. Date of Month		ry Day Year
בי יצטוסי	equires that en signed b	þ	Part II. Other significant condit	ions contributing to death	but not resulting	in the un	derlying cause	given	in Part I.		23e. Did to	bacco use contribu		e cause of death? ably 4 □Unknown
מו חבככ	i: The law re icate has be r, page 2 sho	Completed									24a. Was a autops perform	sy pric med? dea	r to con	osy findings available npletion of cause of
	shysi this o	ation: To Be	25. Was case referred to medical examiner?  1 Yes 27. No  27. Manner of Death Natural 5 Pendia investi	Hospital: Inpat	jury 28b.	utpatient Time of Injury	28c. [	Other: Injury at Work?	4 □ Nurs	sing Hom		ence 6 Other ow injury occurred	Specify	)
	al or Atte s after des il Directo id in by th	Certification:	3 Suicide 6 Could 4 Homicide determ	mined   28e. Place of It	njury - At home, fa etc. <i>(Specify)</i>	arm, stre	et, factory, off	ice		28	Bf. Location (Si City or Town	treet and Number ( n, State)	or Rurai	Route Number,
	ne Hospitt n 24 hours ne Funera pletely fille	edical (	29a. Certifier (Check only one)  Certifying Certifying Communication Com	ng Physician: To the bes i Examiner: On the basis and manner s	of examination at	e, death nd/or inv	occurred at the	ne time, ny opin	date and lion, death	place, a	nd due to the c d at the time, d	ause(s) and mann late and place, and	er as st	ated. the cause(s)
)	To the within the total committee of the tota		29b. Signature and title of certified	the M	1	>	29c. Lic	ense ni	umber D3	390	4/ /	9d. Date signed (I	Nonth, L	2 9 2007
9	3	-	30. Name and address of person	MAGB	death (Item 23a)	(Type, P	170 G	#He	Pa	atr	xent	Pkuy	32	Walson W
	Stat Registra	~	31. Date filed (Month, Day, Year)	1 2007 32. Repis	trar's Signature		069							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #8, perFH, C872, 10/31/07 TT Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Hazel Regina Rohrs October /Medical 26, 2007 <u>8:30₽</u>М 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Village Care Center Parkville Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1928 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Yrs. Director 212- 26-0321 79 Maryland Sept. 18. <del>2007</del> Usual Residence of Decedent r 28a-f show notlfied at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or deical Examiner must be r 8800 Walther Blvd. Apt. United States Of America Funeral death 1302 21234 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Guban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married Married 1 Yes 27 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) e filed within af Hygiene. I **other than** " Elementary/Secondary (0-12) College (1-4or 5+) the Owner Appliance Service Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be t is marked William James Reid Stella Cecelia Duff and i 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum Frederick Rohrs- Husband 8800 Walther Blvd. Apt 1302 Parkville, MD. 21234

Method of Disposition (Name of Disposit Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ✓ Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mam. Gard, Oct. 31, 2007 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licent 22 Name and Address of Facility
EVANS FUNERAL CHAPEL & CREMATION SERVICES 8800 Harford Road Parkville, Maryland 21234 Jacob S 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** xain tumor /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ been signated 1 ☐ Yes 2 ☐ WO 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performe certificate 1∐ Yes 21110 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 28a. Date of Injury (Month, Day Year) 27. Manner of Death Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1. Watural 5 Pending death. investigation 2 Accident M 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital
within 24 hours a
To the Funeral Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 YELYE Chra prists

State Registrar 31. Date filed (Month, Day, Year)

3 1 2007

32. Registrar Signature

Marie D

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month RUBY CATHERINE REMINES 30, 2007 OCTOBER 3:21 A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER HARFORD BEL AIR If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Days 1 □ M 2 🗓 F Hours 218-68-9916 52 July 13, 1955 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐Yes 2 X No. Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Underwood Circle 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth William Blevins Nona Cecila Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Underwood Circle, Bel Air, Maryland 21014 ce of Disposition (Name of Date 20c. Location - City or Town, State George L. Remines Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Grdn 11-2-07 Bel Air, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. tester a Alego 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one couse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): DIABETE Se\_uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MPER CHOL Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy KENAL INSU 1□ Yes 2 No FFICIEN 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide

**Physician** /Medical Examiner Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

**Funeral** 

Director

show

r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

68760

Box (

P.O.

Records,

Division or Vital

d 2 should be filed within 7 in and Mental Hygiene. 7 Is marked other than "n

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev

or other traumatic event,

burial-transit as nse for detached the ģ has

certificate

within 24 hours after death.

To the Funeral Director: After this filled in by the funeral

the State

Hospital

Physician/Medical 2 Completed Be 2 Certification:

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a, Certifier

6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

bPPA, MD 21085

28f. Location (Street and Number or Rural Route Number, City or Town, State)

	lange D	
ne	and address of person who completed cause of death (Item 23a) (Type, Pnn	t)

29c. License number

29d. Date signed (Month, Day, Year)

D 742 Joppa FARM RD 32 Registrar's Signature NANCY E. PROSSER,

31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND J.TEM#20b PerFH G872 of Health and Mental Hygiene 2 0 0 7 34949 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 8:00 PM /Medical 4c County of Death 4a. Facility Name (If not institution, give street and number 4b. City. Town DLocation of Death Examiner (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day) Birthplace (State or Foreign Country) Security Number **Funeral** 216-56-638 Min. 1 ■ M 2 🗷 Months Days Hours Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Himore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 USA Funeral Was Becedent Ever in U.S. Armed Forces? 12. Was De Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Baltimore, Maryland 21215-0036 þ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DQ NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nes 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caught 20a. Method 1 ☐ Burial 2 InCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) years Colon **Physician** Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and the death certificate be executed as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown for use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) detached the 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 this certificate has been sign al director, page 2 should be 1 ☐ Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy To the Hospital or Attending Physician: within 24 hours after Annut. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitai: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**0 2 ER/Outpatient 3 DOA 2 1 Tyes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Characteristics and due to the cause (s) and manner as stated.

Characteristics and due to the cause (s) and due to the cause (s). 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 V 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend #15.perFH.0872.10/31/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** /Medical Bernard Jospeh Reif 7:30 29 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baldwin 13825 Manor Glen Road Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** Days 1**X** M 2□ F Months Hours Min. 215.12.8444 Director 84 .17.1923 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show must be notified at Director 1 ☐ Yes 2 No MD Baltimore Baldwin 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a or 2 Funeral 13825 Manor Glen Road . S 21013 Pages 1 and 2 should be filed within 72 hours after death A . Race - American Indian, items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Xes 2 No If Yes, Give Year or Dates: \ Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Process Checker Western Electric Item 27 is marked other other traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ George L. Reif <u>Mary Burger</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13825 Manor Glen Rd., Baldwin, MD 21013
e of Disposition (Name of Date | 20c. Location - City or Town, State <u>Colleen Regner/daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit, Pages Department of Important: If Its any injury or o 1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 10.30.07 Beltsville, MD 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licensee Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Enter the disease, or complications hat caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed burfal-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached ☐Yes 2☐No 9☐Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy
performed?

1 Yes 2 No or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident the f within 24 hours after death To the Funeral Director; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certiff 29c. License number 29d. Date signed (Month) Day, Year) 10 Y 31. Date filed (Month, Day, 32 Registrar's Signature Year

Registrar

3

			For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of F		-	2007	34951
1	Physicia		1. Decedent's Name (First, Middle, Frederick Ellis	*				2. Date of Dea Month October	Day Year 27, 2007	3. Time of Death 2:30 a M
	/Medic Examin		4a. Facility Name (If not institution, 9520 Colesville				or Location of Death Spring		4c. County of Deat Montgome:	
	Funeral Director				e (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day 10/12/	y Year) 9. Birth Co 1913 Wisc	nplace (State or Foreign untry) Consin
To a	M to		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
a Ca	8a-f sh	Director	MD Montgo	mery	Silver Sp			1.	10g. Citizen of What Co	1 ☐ Yes 2XXVo
with #	3a or 2 st be n		10e. Street and Number 9520 Colesville	Road		10f. Zip Code 20901		1	USA	ariay.
d 21215-0036 fled within 72 hours after death with the Manuland	ince within 7 £ broads and boads with the weapan total Hygiene.  dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 13.1	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 【XNo	Hispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	Specify: Wh	ite
21215-0036	ene. than "natul he Medical	Completed by	15. Decedent (Specify only highes Elementary/Secondary (0-12) 1 2	s Education t grade completed)  College (1-4or 5	Give (Give life. life.	po not use retire iker of F	during most of wo	- 1	16b. Kind of Business/ Tourism	Industry
- 4	_ 0 2	Be	17. Father's Name (First, Middle, I Alfred Isaac Ro	_	Lake		18. Mother's Nar Daisy Ha		Maiden Surname)	
Maryland	marked o	스	19a. Informant's Name/Relationsh		19b. Mailir	ng Address (Stree			er, City or Town, State, 2	Zip Code)
end?	m 27 is		Deedra Liestenfe	eltz/niece				ver Spri	ng, MD 209	
altimore,	ent of H nt: If ite ry or ot		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		20b. Place of Disponsion Chesapea		1 10/		Beltsville	
Balti	perimit. Tages I aring smooth of Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service	icengee M	M787 2	2. Name and Addr	ess of Facility $\mathrm{R} a$		al & Crema ag, MD 2091	
X F	hysician /Medical :xaminer	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cong Due to (or as c.	a consequence of):	CARDO				Approximate Interval Between Onset and Death
.O. Box 68760, A	e attending d for use as	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	2 Fetal death 3	□Ectopic pregnan □ Other (specify)	еу		23d. Date of de Month	livery Day Year
ds, P	signed b	by	Part II. Other significant condition	ns contributing to death b	out not resulting in the u	inderlying cause g	iven in Part I.	23e. Did to	obacco use contribute to	o the cause of death? robably 4 □Unknown
l Records, P.O	cate has been si	Completed				· · · · · · · · · · · · · · · · · · ·		24a. Was autop perfo 1 Yes	prior to death?	utopsy findings available completion of cause of
Vita		Be	25. Was case referred to medical examiner?	Hospital:	ent 2 ☐ ER/Outpatie	nt 3 DOA	her:	ath (Check only o	_	noify)
Division or	or Attending Frings after death. Director: After this in by the funeral di	Certification: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin investig 3 Suicide 6 Could r	ation ot be 28e. Place of in	ury Year) 28b. Time of Injury	of 28c. Inj We M 1 [	Yes 2 No	28d. Describe i	now injury occurred Street and Number or R	
בַּ			4   nothicide	g Physician: To the best	of my knowledge dea	th occurred at the	time, date and place	ļ		s stated.
1	within 24 hours after To the Funeral Dir completely filled in	ledical	29a. Certifier 1	Examiner: On the basis of and manner st	of examination and/or in	nvestigation, in my	opinion, death occ	curred at the time,	date and place, and du	e to the cause(s)
Ę	within 2  To the complet	Me	29b. Signature and title of certific	ALLA	1 JOFAC	29c. Licer	5839		29d. Date signed (Mon	tn, Day, Year)
	X	!	30. Name and address of person	who completed cause of	death (Item 23a) (Type	, Print)	# 7.2.4 /	Barbar	M ND 7	0814
£ -	Sta Regist		31. Date filed (Month, Day, Year) OCT 3	32. Segisti	rar's Signature	all s	T 40 P/T 1.	JUIPIVA	DETOGEN 25 DA, MD Z	- 01 )

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 11.30 M 122LEY 26 2007 NHOL 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** USA RANDALLSTOWN HOSPITAL NORTHWEST If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) June 23 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Days Hours Min. 1 M 2 □ F 60 214-48-1809 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 1 ☐Yes 2 XNo Baltimore Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or 7 3620 Florida Road 21244 USA Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) tems 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: , or l 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: ģ 3 Widowed 4 Divorced "natural", Completed or than "natur the Medical I 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Potts & Callahan 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental I Ε. Clara Lotz Riley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maria A. Riley (spouse) 3620 Florida Road, Baltimore, MD 21244 permit. Pages 1 and:
Department of Health
Important: If Item 27
any injury or other tr 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 2007 Metro Crematory Inc. Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signatu of Funeral Sec 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, that caus Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOHYOPATHY Physician /Medical Due to (or as a consequence of): **Examiner** HYPONATIZEMI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed -EUKO CYTO SI burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, I HRMIZOCY TO PENIA Physician/Medical If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 No 24a. Was an autopsy performed: 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 2007 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VENKATA ICEDDIVARI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend #20b&c Per FH g873 11/08 Cortificate of Death

Reg. No. Reg. No. 2 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Month Inez outibus /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year | If Under 24 H Wirth will de rthplace (State or Foreign (In vrs. last birthday) 9. Birthplace Country) **Funeral** Date of Birth (Month, Day, Year) 1 ☐ M 2X F Months Days Hours Min. Director 212-22-6378 7-12-1919 MD Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland 1 and Mental Hygiene. r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 No MD **Baltimore** Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 3239 Kelox Road 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African-American 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Damestic Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any heiry or other traumatic evene. Charles Hassell 2 Captolia Bell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Inez Reid/Daughter 3239 Kelox Rd., Gwynn Oak, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Conference of the place of the 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 11-1-07 Woodlawn, ME Balto, Md. e of Funeral Service Lio 22. Name and Address of Facility lie Fineral Home P.A. of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Fibrillation Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit siclan and burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1⊟ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

OCT

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier® 0.0.7

			State of M	laryland /	Departme Certifica			nd Mental H		7 34954
		1. Decedent's Name (First, Middle, La.	st)		Ochanoe	10 01 1	Dealit	2. Dete of	Reg. No.	3. Time of Death
	Physicia		_					Month	Dey	Yeer
1	/Medica	4 5 100 11 11 11 11 11 11 11 11		·)		1 4	b. City. Tow	vn, or Location of D		
j	Examine	MARYLAND GEN					_	IMORE GIT		
	Funeral	5. Social Security Number 6. S		ge (in yrs. lest b	irth day) If Und	er 1 Year	If Under 2		Birth Day, Year)	Birthplece (State or Foreign
	Funeral Director	218-28-4275	□M 2₹F	74	Yrs. Month	Days	Hours	Min. (Month, 08/07	Day, Year) /1933	Maryland
	D.	Usuel Residence of Decedent								
	show thou	10a. State 10b. County		10c. City, To	wn or Location					10d. Inside City Limits 11 Yes 2 □ No
	Ba-f	Maryland			Baltimo					
	Vith th	10e. Street end Number			10f. Z	ip Code			10g. Citizen of V	What Country?
	ifier death with the Ma w tems 23a or 28a-f s niner must be notified	900 Franklin Stre			10.19		1223	-0.0		e - American Indien,
	er de	1	12. Wes Decedent	7	If Yes, sp	ecify Cuba	ispanic Orig in, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	Blac	ck, White, etc.
20	rs aff	3 XWidowed 4 □ Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	NO	1 ☐ Yes	2⊠ No	Specify:		Specify	Black
21215-0020	within 72 hours after death with the Marylend ene. than "natural", or flems 23a or 28a-f show fre Medical Examiner must be notified at	15. Decedent's Ed		16	a. Decedent's Us	ual Occup	ation		16b. Kind of Bu	usiness/Industry
215	led within 72 ho lygiene. her than "natura it, the Medical.	(Specify only highest gre	de completed) College (1-4or	54)	(Give kind of w life. DO NOT	rork done d use retired	during most f)	of working		
2	d wit	11	conoge (1 401	017	House	vife			Homem	aker
g	be file d other	17. Father's Name (First, Middle, Last)							dle, Maiden Suman	ne)
yla	should be filed wand Mental Hygier to marked other to umatic event, the	Walter Gardner					Jose	ephine Ho	lland	
Maryland	2 sh and is m	19a. Informant's Name/Relationship (1	Type, Print)						mber, City or Town,	
ď	and lealth m 27		<u>ighter</u>						, Marylan	
0	it of the or of or of	20a. Method of Disposition	Removal from State		of Disposition (N ery, crematory or	_		Date		City or Town, State
Baltimore,	t. Pertmentant:	4 □ Donation 5 □ Other (Specify		King !	Mem. Par				+	ore, Maryland
Ba	parmit. Peges 1 and 2 should be filed within 72 hours after death with the Manylen Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinat must be notified at once.	21. Signeture of Funeral Service Lican	1588							nes F/H, P.A.
		Many	· /		4611	Park	Hgts.	Ave., Ba	ltimore,	Maryland 21215
1		23a. Part1. Enter the diseese, or companies shock, or heart failure. List only	one cause on eech	a the deeth. Do ine.	not enter the m	ae or ayın	g, such es c	cardiac or respirator	y arrest,	Approximete Interval Between Onset end Death
Je.	Physician /Medical	Immediate Cause (Final	Λ	- И.,	AR DIAL	1		,		
	Examiner	disease or condition resulting in deeth)	e. 4CUTI				221101	<u> </u>		Unknown.
			CORONAR	Λ	consequence of		<			One year
	ate be executed hysician and the burial-trensit	Sequentially list conditions	b. CORONAL		consequence of					one year
Ö,	a exe	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury								i
8760,	cate be executed oblysician and the burial-trensit	that initiated events resulting in death) Last	С.	Due to (or es e	consequence of	:		,		
ğ X	entific ling p		d							
Box	law requires that tha death certifical as been signed by the ettending place should be detached for use as incleted by Dhyselvian Allas		·							İ
P.0.	the e	Pert fl. Other significent conditions co	ontributing to death b	out not resulting	in the underlying	cause give	en in Part I.	23b. D	id tobacco use co	ntribute to the cause of death?
٥.	that the							1	☐ Yes 2⊠ No	3 Probably 4 Unknown
Records,	Tha law requires the state has been signed page 2 should be designed.							24a. W	es en eutopsy	24b. Were autopsy findings
Ö	been shou							P	erformed?	available prior to completion of cause of death?
Re E	a law							,	☐ Yes 2 No	1 ☐ Yes 2 🛣 No
<u>ta</u>	Han: Tilent entificat						26 Place	of Deeth (Check on		1 1 1 1 1 1
<u> </u>	hysicle his cert al direct		Hospital: 1 ☐ Inpati	ent 2 ER/O	utpatient 3	OA Oth	OF:		esidence 6 Oth	er (Specify)
0	g Ph er thi		28e. Date of Inju	ury 28b.	Time of Injury	28c. Injun Worl	/ et k?	28d. Descri	be how injury occur	red
<u> </u>	ath. Ar: Aff	1 ⊠Naturel 5 ☐ Pending 2 ☐ Accident investigetion		,	М		Yes 2□N			
Division of Vital	tal or Attending P is after death. al Director: After t led in by the funer	3 ☐ Suicide 6 ☐ Could not be determined	286. Pieca of in	jury - At home, f c. (Specify)	arm, street, facto	ry, office		28f. Locatio City or	n (Street and Numb Town, Stete)	er or Rurel Route Number,
	n 24 hourn n 24 hourn ne Funer pletaly fil	29a. Certifier 12. Certifying Phy (Check only one) 2 Medical Exam		f examinetion e						anner as steted. and due to the cause(s)
	ithin (ithin on the omple		and manner st	5.6u.	2	c. License	e number		29d. Date signe	d (Month, Day, Year)
	F 3 F 8	102 1-171	125		1	15351	7		October	30, 2007
	W.X	30. Neme end address of person who d	completed cause of a	leath (Item 23e)		, , , ) )	7		- COSER	, -, -, -,
	1	ARNEL MENDOZA TAGLE	1 .			BALTI	MORE	MARYLAN	10 21202	-
	State	31. Dete filed (Month, Day, Year)		er's Signeture	2					
	Registrar	OCT 3 1 200	7 820000	All S	Board D					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State Amend #1,perMD,0872, 10/31/07 TT Certificate of Death David Spann 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Zann /Medical ation of Deatl 4a. Facility Name (If not institution, give street and 4b. City, Town, or Loc Examiner If Under 1 Year | If Under 24 Hrs. 5. Social Security Numb Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F 419-10-8887 Director Alabama 12/05/1920 86 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show 10b. County 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√∑ No Maryland Director Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8812 Stonehaven Road 21133 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify. 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Donut Shop 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' College (1-4or 5+) 2+ Elementary/Secondary (0-12) Self-employed Fntrepreneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Samuel Spann <u> Hattie (unknown)</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 97 Jerome Spann / Son Attenborough Drive, Rosedale, Maryland 21237 injury or other Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 NOther (Specific Fintombment Woodlawn Cemetery 11/02/2007 Woodlawn, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. ture of Funeral Servi 4611 Park Hgts. Ave., Baltimore, Maryland 21215 ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, physician Physician/Medical as the t the attending IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. detached 9 I Inknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 4 Onknown 1 🗌 Yes 2 No 3 Probably page 2 should Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy certificate 1∐ Yes Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After Natural 5 Pending investigation 1 Tes 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 30. Name and address of person cause of death (Ite USTOUN, Maryland 21133 Evica ToBIN Muldfow, 540 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Ma		epartme Certifica			nd Mental H	ygien Reg. N	2001	34956
	Dhuais		1. Decedent's Name (First, Middle, Las	t)					2. Date of D		av Year	3. Time of Death
	Physic /Medi		Walter G. Strze	lczyk					O ctob	er c	27 2001	10041M
	Exami	ner	4a. Facility Name (If not institution, give	112121		4b. Ci	ity, Town, o	Location of	Death	4	c. County of Death	(
			5. Social Security Number 6. Se	Verside	(In yrs. last birth	day) If Un	De der 1 Year	If Under 2	4 yrs. 8. Date of E	ligh	ARRED	place (State or Foreign
	Funeral Director			X M 2□F	79 Yı	Month		Hours	Min. Mar . 28	<sup>a</sup> 1 92	8 Mary	and
			Usual Residence of Decedent									
\/	arylar ehow	_	10a. State 10b. County Har	ford	10c. City, Town	or Location Bel Ai:	r					10d. Inside City Limits 1 ☐ Yes X☐ No
*	the M	Director	10e. Street and Number	IOIU						10-0		
0	within 72 hours after death with the Maryland ene. then "naturet", or Iteme 23a or 28a-f ehow he Medical Examiner must be notified at		102 West Heather	Road		101.	Zip Code 2	1014		10g. C	itizen of What Coul USA	ntry r
	death	by Funeral	11. Marital Status	12. Was Decedent E	ever in U.S.	13. Was De	cedent of H	lispanic Origi	n? (Specify Yes or N	10-	14. Race - Americ	
2 9	or Ite	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 XYes 2 ☐ N If Yes, Give	io				Puerto Rican, etc.)		Black, White,	
9 8	urel'.		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:							Specify: Whi	
15	n 72 h	Completed	15. Decedent's Ed (Specify only highest grad		16a. D	ecedent's U Give kind of	sual Occup work done	ation during most of d)	of working		Kind of Business/In	
+ 212	withi iene. r then	mo di	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Polic					ice Depar	
() E	e filed at Hygid other vent,	BeC	17. Father's Name (First, Middle, Last)						s Name (First, Midd		on Sumame)	
<u>a</u>	should be ind Mental i marked o	70 6	Martin Strzelcz	yk				Mar	y Iwaniec			
Maryland		1	19a. Informant's Name/Relationship (T						or Rural Route Num			
	5 = 2 -		Mariann Perry-da  20a. Method of Disposition	ughter	20b. Place of D			er Roa	nd-Bel Air	-		
Walt	8	- 55	1 ☐ Burial 2√☐ Cremation 3 ☐ I		EVANS FI	JNEKAT	CHAP				Location - City or To st Hill, Mar	
E C	permit. Pege Depertment of Important: If eny injury or once.	1	4 □Donation 5 □ Other (Specify,  21. Signature of Funeral Service Licens		AND CRE			Air   IU ss of Facility	) <del>-</del> 30-07	-		
	permit. Depertritimports eny trip.		Pending 60	ns 4		EVANS	FUNER	AT. CHA	OPEL 3 NE OVICES For	wpor est	rt Drive Hill.Mar	yland <sup>21050</sup>
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death. Do no		EMATI lode of dyin		ardiac or respiratory	arrest,		Approximate
1	Physician		Immediate Cause (Final disease or condition	Cala	him . In	200	1	X	ccider	1		Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of)	SCA	LAV	7)	cciner	+1-		
	Examiner		Sequentially list conditions	b								
$\mathcal{N}_{\mathcal{I}}$	led sit	ulue	Requentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of)	:						
~	cate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of)	:						
8760,	cate be e physicien the buria	dical		d.								
9		Medi								ŧ т		
Вох	The law requires thet the death certifi ate has been signed by the attending bage 2 should be detached for use es	by Physician/Me	230. Was decedent pregnant	23c. If yes, outcome of		3 □Ectopic	pregnancy				23d. Date of delive	
E	e dea the at hed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at t		5 Other					Month	Day Year
P.O.	thet the detected detached	F.	Part II. Other significant conditions co	ntributing to death but	t not resulting in th	ne underlying	Cause on	en in Part I	23a Did	tobacco	use contribute to the	he cause of death?
Division of Vital Records,	signe d be	d b	Maho	TIMPIOC	Dein	2. +	y outsto giv	on arr arr.		Yes :		
Š	w requir	lete	47/18	1 Mer	Y	CAL	9		24a. Wa			mey findings available
Re	The lav	Completed							aut per	opsy formed?	death?	ppsy findings available impletion of cause of
ta	iclan: Th certificate ector, pag	BeC	25. Was case referred to dical					26 Place o	1 ☐ Yes		0 1 ☐ Yes	2 No
>	d is	To B	examiner? 1 Yes 2 No	Hospital: 1   Inpatien	nt 2 ER/Outp	atient 3 1	DOA Oth	ar /	ing Home 5 ☐ Re		6 Other (Specif	(y)
0	ling Phys	on:	27. Man of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tim		28c. Injun World	y at k?	28d. Describe	how inj	ury occurred	
sio	Attending r death. ctor: After y the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be			М		Yes 2 □ No				
i i	for Attendate death Director:	art	4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm . <i>(Specify)</i>	, street, fact	ory, office		28f. Location City or To	(Street a	and Number or Rura te)	al Route Number,
	Hospital 14 hours Funeral tely filled	a C	29a. Certifier 1 Certifying Phy	sician: To the best of	f my knowledge o	eath occurre	ed at the tim	ne, date and	place, and due to the	B Carren	s) and manner as s	tated
(3	To the Hospitat or Attending Pi within 24 hours after death. To the Funeral Director: After the completely filled in Fy the funera	ledical	(Check only 2 Medical Examinations)	ner. On the pasis of and manner state	examination and/o	or investigation	on, in my of	pinion, death	occurred at the time	, date an	nd place, and due to	o the cause(s)
1	To the To the Comp	Me	29b. Signature and title of certifier		)	2	29c. License	e number		29d. D	ate signed (Month,	Day, Year)
			1 ( Il annu	1 Ml 4	-wo		D	19TF	3	Oã	Johan	18 2007
	(0		30. Name and address of person who co	ompleted cause of de	ath (Item 23 ) (Ty	rpe, Print)	1	and.	Aviet	XL	01-10-	n. I
300	Ψ		31. Date filed (Month, Day, Year)	727	r's Signature	8 40	7.	V ( VV )	-//~/		Trater	(00) 1019 and
	Sta Registr	-	5 Sato mod (Month, Day, 1941)	32 Hegistrar	3 Signature	Dead	P.					- /

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 200 nne /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Mari ALTIMORE IMONIUM Year If Under 24 Hrs Days Hours Min. 5. Social Security Number 7. Age (In ) 8. Date of Birth (Month, Day, Birthplace (State or Fpreign
 Country) **Funeral** Months Days 1□M 2XF 220-14-372 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. and 2 should be filed within 72 hours after eafth and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Whit Specify Completed by 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) mine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health an.
Important: if them 27 is m. any injury or other. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other p ra 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 20c. Location - City or Town, State 3 Removal from State 4 □ Donation 5 □ Other (Specify) 31/0 10 ALTIMORE 1 emeter 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8 30 How ford Rd., BALTIMOS MD21234 mations 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PANCREATIC CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has e 2 s page certificate 2**X** No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home After this 5 Residence 6 NOther (Specify) HOSPICE 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 □ No neral Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

4

2007

27,

OCTOBER

ANNE SCHILLER

Registrar
DHMH 17 Rev 1/2001

State

2300 DULANEY VALLEY RD.

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 34958 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Jack G. Sanders 10-28-2007 555A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 233 Forest Green Rd Harford Aberdeen If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Director 217-14-4187 84 01-27-1923 West Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must han activity. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Haywood NC Waynesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Bage St 28786 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2□No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Ď 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist BG&E 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Boyd Sanders Winifried Grimes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 233 Forest Green Rd Aberdeen, MD 21001 Charlotte Dvorak (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 10-30-2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Dice hee 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mount of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner (or as a consequence of) The law requires that the death certificate be executed and burial-tra (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death the 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2□ No To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No Costano Certification: To 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 6 2 Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury 5 ☐Pending investigation 1 Natural 2 Accident (Month, Day Year) 1 ☐ Yes 2 □ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and panner stated. (Check only one) 29c. License number 29b. Signature and 29d. Date signed (Month, Day, Year) D54749 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Reilly, MD 801 Toll House Ave D1 Frederick, MD 21271 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 3 0CTRegistrar

The law requires that the death certificate be executed P.O. Box 68760, Division or Vital Records, or Attending Physician:

within 24 hours after death.

To the Funeral Director: After this o completely filled in by the funeral dire the Hospital

Y

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0064502

29d. Date signed (Month, Day, Year) Oct. 27, 2007

Brian Carpenter 9901 Medical Center Drive Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Tuli, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

> РМ 2007 1:05 4c. County of Death Montgomery Birthplace (State or Foreign Country) September 23, 1929 India 10d. Inside City Limits 1 ☐ Yes 2 X No 10g. Citizen of What Country? United States 14. Race - American Indian. Specify: Asian Indian 16b. Kind of Business/Industry Maintenance Engineering 20c. Location - City or Town, State Bethesda, Maryland Approximate Interval Between Onset and Death 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
>
> 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 10810 Darnestown Road, #202, Gaithersburg, MD 20878

10

State Registrar

Raman R.

31. Date filed (Month, Day, Year)

			1 - State Registrar	State of Ma	aryland		tificate		ealth and N Death		Reg. No.	200	17	31	96
	Physicia	an	1. Decedent's Name (First, Middle, Last)  KAREN LEE	SEIGEL						Month	Day		ear	J: 0	7 PM
	/Medic	-	4a. Facility Name (If not institution, give str	own, or	Location of Death	OCTOBE		7 Zo County of I	Death	•					
	Lxaiiiii	-1	HOWARD COUNTY GENE	RAL HO	SPITA	46	COLI				Lt	OWA	RD		
	Funeral Director		5. Social Security Number 6. Sex	7. Ag	e (In yrs. la 52	ast birthday) Yrs.		1 Year Days	Hours Min.	8. Date of Bir (Month, Da 10/02/	th	l a	Birthpla Country	ce (State y) NY	e or Foreign
	w		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation						100	d. Inside	City Limits
	Maryli -f sho fled at	ţo	MD HOWARD		LA	UREL								1 □ Y	es 2M No
	h the or 28a e notif	Director	10e. Street and Number				10f. Zip (	Code			10g. Citi	zen of Wha	t Countr	y?	
	ath wii 23a c	ral	11328 CASTLEWOOD C						0723			14 Page	USA	n Indian	
<b>036</b> urs after de	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	. Was Decedent Armed Forces? 1 ☐ Yes 2 🚺 I If Yes, Give Year or Dates:	Ever in U.S No	ver in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1  Yes 2 No Specify:						14. Race - American Indian, Black, White, etc.  Specify: WHITE			
5-0036	72 hou natura lical E	eted	15. Decedent's Educa (Specify only highest grade of	tion completed)		16a. Deced	dent's Usua kind of wor	l Occupa k done d	ation during most of worl	king	16b. K	nd of Busin	ess/Indu	stry	
2	vithin ane.  Than "  Le Mec	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. I			ONIST		NI	JTRITI	ON F	בחוום:	ATION
Q 2	filed v Hygie other t	ပ္ပ	17. Father's Name (First, Middle, Last)				1107	1/11/	18. Mother's Nam	ne (First, Middle			OIL		111011
<u>lan</u>	should be nd Mental marked o	To Be	CONRAD			ALT	MAN		HELEN					WOL	FF
Maryland 21	2 salar	•	19a. Informant's Name/Relationship (Type	-					and Number or Ru		JREL .		ate, Zip 0 207		
	s 1 and if Health Item 27 other to		ALAN SEIGEL / HUS  20a. Method of Disposition	DANU	20b. PI	ace of Dispo	sition (Nam	e of	NOOD COUP	Date LAC		ocation - Cit			
no D	0 0 <del>-</del> -		1 ☐ Burial 2 ☐ Cremation 3 🛣 Read 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	M	EMORIA	SCENT	herplac !K	10/30	/2007	PFN	INSAUK	ŒN.	NJ	
altimore,	permit. Pag Department Important: I any Injury c		21. Signature of Funeral Service Licensee	7		22	2. Name and	d Addres	ss of Facility SC	L LEVIN	NOON	& BRO	S.,	INC	
<u>m</u>	o a La		Koto /a	1000	_				TERSTOWN			SVILL			
1	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	SEPTIC	ne. - SH	ock	er the mode	e of dyin	g, such as cardiac	or respiratory a	arrest,			Approxin Interval I Onset ar	Between
den.	/Medical Examiner			Due to (or as			ock							1 4	DAY
L		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or as	a consequ	ience of):			,					, ,	NEER
	ficate be executed physician and sthe burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	ACUTE Due to (or as	my	OCALL	DIAL	INFA	ACTTON					-	VECK
60,	be exe	al Ex	resulting in death) East	Due to (or as	a consequ	ience or):									
68760,	ficate g physics the	edical	d.												
D. Box	To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	⊒Ectopic pr ⊒ Other <i>(sp</i>		,		23d. Date of delivery Month Day Year							
P.O.	that the ed by detacl		Part II. Other significant conditions contr	ibuting to death b	out not resu	ılting in the u	nderlying ca	ause giv	en in Part I.	23e. Did	tobacco	use contrib	ute to the	e cause	of death?
Vital Records,	quires n sign ald be	d by	ANDREXIA NER	VOSA						1 🗆	Yes 2	<b>□</b> √0 3	☐ Proba	ably 4	□Unknown
S	aw rec is bee 2 shou	Completed								24a. Was	s an opsy	24b. We	re autop	sy findin	gs available of cause of
ž	The lavate has	)om								perf 1∐ Yes	ormed?	- de	ath? Yes		, 54455 51
/ita	cian: ertifica ector,	Be (	25. Was case referred to medical examiner?	anital.				Oth	26. Place of Dea						
or.	ding Physician: The n. After this certificate ha funeral director, page	ပ္	1 ☐ Yes 2 ☑ No  27. Manner of Death	spital: 1 Inpation 28a. Date of Inju		ER/Outpatie		Oth	4 LI Nursing F	lome 5 ☐ Res				)	
O	th. : After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury	М	Wor	k? Yes 2∐No			•			
Division or	al or Atter s after dea Il Director d in by the	Certification:	2 Accident 3 Suicide 6 Could not be determined 4 Homicide 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Recommendation) 28f. Location (Street and Number or Recommendation) 28f. Location (Street and Number or Recommendation)								or Rural	Route N	lumber,		
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical C	29a, Certifier 1 Certifying Physi (Check only one) 2 Medical Examina	cian: To the best er: On the basis of and manner st	of examina	wledge, deat tion and/or in	nvestigation	, in my o	opinion, death occu	e, and due to the urred at the time	e, date ar	id place, ar	d due to	the caus	
	Within Com	Ž	29b. Signature and title of certifier	17)			290		e number			ate signed			
)	5		4//		-			り6	3242		OCTO	OER	27,	200	7
,	20		30. Name and address of person who con					ΔV	SVITE ZOO	2 101 4	mBI	A. MA	RYLA	WD	21044
	Sta	te.	31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ture A	AN IN	7	37,70 230	0000		-7 - 111	1 -1		

Registrar DHMH 17 Rev 1/2001 OCT 3 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 8:00 P OCTOBER 28 2007 STEINBERG JEROME /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR 8. Date of Birth (Month, Day, Year) 01/23/1935 or Foreign If Under 1 Year **Funeral** Days 1 M 2 □ F 72 219-28-9810 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No BALTIMORE MD OWINGS MILLS Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5112 STONE SHOP CIRCLE 21117 U.S.A. Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) ACCOUNTING ACCOUNTANT 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ROSEN **STEINBERG** RODIE MORRIS ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5112 STONE SHOP CIRCLE - OWINGS MILLS, MD 21117 ARLINE STEINBERG / WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/30/2007 BALTIMORE, MD ISRAEL CONG 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS.. INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ean Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) physician ar s the burial-t Physician/Medical as 1 IF FEMALE: use 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 ☐ Live birth Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4□Pregnant at time of death detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1∐ Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 1 Yes 2 No 1 Inpatient 2 ER/Outpatient ٩ 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

P.O. Box 68760 Records, Division or Vital

(E 31. Date filed (Month, Day, Year) 31

29b. Signature and title of certifier

30. Name and address of person who completed cause of greath (Item 23a) (Type, Print) 32: Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Balto and Zizox

medel

			State of Ma	aryland / Dep			nd Mei	ntal Hygi	ene	7	21.002
			Registrar  1. Decedent's Name (First, Middle, Last)	<i>Ce</i>	ertificate of	Death	2.	Re-	g. No. 💪 U	101	3 4 9 0 3 3. Time of Death
	Physici /Media		Anthony M.		Sen.		a	Month to be 4	Day	Year	TULEM
	Examir		4a. Faeility Name (If not institution, give street and number)	. / /	4b. City, Town, o	r Location of I	Death		4c. County		. 7 - 8
÷	Firmanal	S.	5. Social Security Number Sex 7. Age	An yrs. last birthday	) If Under 1 Year	MC/L C	Hrs. 8	Date of Birth		9 Rintho	lace (State or Foreign
b	Funeral Director		157-26-4547 1□xM 2□F	71 Yrs.	Months Days		Min. 0	Date of Birth (Month, Day, 1/04/19	Year) <b>936</b>	Coun	nJ
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	_ocation					1	0d. Inside City Limits
	Maryl r-f sho fied a	tor	NJ Somerset		Somerv	i11e					1 DXYes 2 □ No
	with the 3a or 28a t be not	I Director	10e. Street and Number 379 East Main Street	-	10f. Zip Code	08876		10	g. Citizen of \		try?
	death	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Decedent of H If Yes, specify Cub:	lispanic Origin	n? (Specify	y Yes or No-		ce - Americ	
036	be filed within 72 hours after death with the Maryland ital Hygiene. In a constant the matural, or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 See 2 N If Yes 2 N If Yes Give Year or Dates:	io	1 ☐ Yes 2 No	Specify:	rueno nic	an, etc.)		ck, White, o y: <b>Whi</b>	
15-0036	72 ho 'natur dical I	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occup re kind of work done DO NOT use retired	ation during most o	of working	1	6b. Kind of B	usiness/Inc	lustry
121	within ene. than '	Jdwc	Elementary/Secondary (0-12) College (1-4or 5-	+)	DO NOT use retired roker – Re		5		Rea	1 Est	ate
מפר	e filed al Hygi other vent, t	Be C	17. Father's Name (First, Middle, Last)		IONEI IN	18. Mother's		irst, Middle, M			
Maryland		To	Michael Sena			Carme		Scarpor			
Ma	d2s thar 7 is trau		19a. Informant's Name/Relationship (Type. Print)  Mary Sena / Wife		ling Address (Street East Mair						,
e,	the He		20a. Method of Disposition	20b. Place of Disp	position (Name of ematory or other place		Date		Oc. Location -	City or To	wn, State
Battimore,	Pa Then ant: ury		1 ☐ Burial 2 ☐ Cremation 3☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Enterthement			LCuiii	11/2/		Bridge		, NJ
g n	permit. Departi Imports any inj		21. Signature of Funeral Service Licensee	Shall "	22. Name and Addre Charles I 1501 East	ss of Facility L• Stev t Fort	vens Aven	Funeral ue, Bal	L Home Ltimore	Inc.	21230
		W 113	23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not er	nter the mode of dyir	ng, such as ca	ardiac or re	espiratory arres	st,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	consequence of):	morran	yari	res	+		+	10 Hours
	Examiner		Sequentially list conditions b. Duode	woiei	unosto	my L	ea	1c			1 Day
	led sit	niner	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of	- , ,	1	1				1 111
'n	cate be executed physician and the burial-transit	Examiner	that initiated events	consequence of):	upula	R 170	LEN	oma			/ Week
2/pn	ate be hysicia the bur	dical	d				_				
٥	certific iding p	/Mec	IF FEMALE: 23c. If yes, outcome p	of pregnancy							
7. BOX	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	hysician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown	2 Fetal death 3	□Ectopic pre <b>g</b> nancy □ Other <i>(specify)</i> _	<u>'</u>		····		te of delive onth	ry Day Year
7.	requires that the een signed by th hould be detache	Δ.	Part II. Other significant conditions contributing to death but	t not resulting in the	underlying cause give	en in Part I.		23e. Did toba	acco use cont	ribute to th	e cause of death?
ecoras	en sign	ed by				-		1 ☐ Yes	2 <b>N</b> O	3 ☐ Prob	ably 4 □Unknown
ecc	e law n has be	Completed						24a. Was an autopsy		prior to cor	osy findings available opletion of cause of
VIII	in: The ificate ha		25. Was case referred to medical						□No	death? 1 ☐ Yes	2X No
	ysicia is cert directe	To Be	examiner?  1 Yes 2 No Hospital: 1 Departien	nt 2 ☐ ER/Outpatie	ent 3 DOA Oth			theck only one) 5 ☐ Residen		er (Specifi	()
5	Ing Ph		27. Manner of Death 1		of 28c. Injur Wor			. Describe how			/
VISION	vttend death. ctor: / y the fi	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	ry - At home, farm, st	1	Yes 2 ☐ No		Location (Stre	ot and Numb	or or Dura	Route Number,
2	s after al Dire	Certification:	4 ☐ Homicide determined building, etc.	(Specify)	arout, lactory, office		201.	City or Town,	State)	er or nura	noute Nurriber,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state.	examination and/or i	ith occurred at the tir nvestigation, in my o	me, date and popinion, death	place, and occurred	due to the cau at the time, dat	use(s) and ma te and place,	anner as st and due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of confinence		29c. License		-		d. Date signe		
	.1		THIS		BE	5-0	000	) 00	TOBE	8 2	5,2007
	25		30. Name and address of person who completed chase of de TREWS ELLISON THE JOHNS H		, Print)						
B	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar	r's Signature	MALL OUN	N - 1701	463	TI, DAL	1 1 11017	C, 19	IN CICK!
3	Registra	ar	OCT 3 1 2007	42 JE 19							

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

07-08166 David Anthony Tho	omas										<b>opies Are L</b> al Hygiene	egible	е.		
Physician/	1- F	or State histrar Decedent's Name					tificate c				2. Date of D	Reg. No	200	7 3496 3. Time of Death	
Medical Examine	•	DAVID			MAS JR	•					Month October	20, 20		0214 hrs	
	4a	Facility Name (in University H		n, give str	eet and numbe	er)		4b. City, Town, or Location of Death  Baltimore					4c. County of Death N/A		
Funeral Director	5.	Social Security N 217-06-		6. Sex		Age (In yrs. Ia	st birthday) Yı	If Unde Months			Birth(MM 2-19	VDD/YYYY) 9. Birt Foreig Cou			
ıny		ual Residence of a. State	Decedent 10b. County			10c. City,	Town or Loca	ation						10d. Inside City Limits	
and show :	5	MD.	N,	/ A		BA	LTIMO	RE						1 X Yes 2 No	
ath with the Maryland items 23a or 28a-f show any lost be notified at once.		e. Street and Nur 1949 W.						10f. Zip	Code 212	17		10g. Cit	tizen of What Cour		
Baltimore, MD 21215-0036  pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 1 3	Marital Status  Never Marrie  Widowed		arried 1	. Was Decede Armed Force Yes es, Give Year			Yes, specif	fy Cuba		in? ( Specify Yes or Puerto Rican, etc.)	No-	White, etc.	can Indian, Black, ACK	
ours after attural" tamine	∑	5. Decedent's Ed		Or i	lates:	ompleted)	16a. Decede	ent's Usual	Occupa	ition (Give k	16b.	16b. Kind of Business/Industry			
5-0036 led within 72 hour tygiene. other than "natu be Medical Exan	Indicate	Elementary/Secondary (0-12)						most of wor LERK	King ille	E. DO NOT	use retired)		FOOD		
215-0 be filed wintal Hygie rked other ent, the M	וט	I DAVID THOMAS SR. I DONNETTE DIXON							n Surname)						
MD 21215-0036 d 2 should be filed within 7 d 2 should be filed within 7 in 27 is marked other than numatic event, the Medica	19			EXON(AUNT)							ber or Rural Route N BALTIMO				
Baltimore, loemit. Pages I and Department of Heal Important: If item nijury or other tra	1	= / '	XCremetion		Removal from	State C	Place of Disporter or CTRO CF	other place)	)	· 1	Date 10-29-200	20c. Location - City or Town, State  7 BALTIMORE, MARYLAND			
Baltir permit. I Departme Importation	21. Signature of Facility PHILLIPS FUNERAL HOME,														
Physician /Medical :xaminer	Physician  23a. at I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head for the cause on each line.  Multiple Injuries.									Approximate Interval Between Onset and Death					
. Jed	Sequentially list conditions, b.  if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause														
vecuted and -transit															
be execu sician and urial - fra	3   1	UNPENDED AMENDED													
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitication: To Be Completed by Physician/Medical Esterician/Medical	1 IF 23b	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown  23d. Date of delivery Month Day													
P.O. I so that the gned by the e detached	3	rt II. Other signi	ficant condit	ions cor	ntributing to de	ath but not re	esulting in the	e underlying	) cause	given in Pa				the cause of death?	
Records, The law requires ficate has been sig											pe	as an itopsy erformed? es 2	prior to death?	utopsy findings available completion of cause of es 2 No	
ital   ician: ician: s certifi	25	Was case reference examiner?	red to medica		ital: 1 🗸 Inpa	tiant 2	ER/Outpatie		26.Plac	e of Death of Other	(Check only one)  Nursing Home 5	Boois	dence 6 Othe		
ling Phys After thi	27	1 Yes  Manner of Deat  Natural			28a. Date of I	niury	28b. Time o	L	28c. Inj	ury at Work	? 28d. Descri	be how ir	njury occurred		
Division o  To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afteompletely filled in by the fune	2 3	Accident Suicide	6 Coul	atigation d not be mined	Oct 20, 200 28e. Place of	)7 Injury - At ho	0152 hrs	reet, factory		Yes 2 V	c. 28f. Locatio	n. State)	and Number or Ru	ural Route Number, City	
To the Hospita within 24 hours Completely fille	29 (Ci oni	Homicide a. Certifier 1	Certifying Pl	nysician:	(Specify) S To the best of the basis of e	my knowledg	ge, death occ	curred at the	e time, o	date and pla	ace, and due to the courred at the time, d	ause(s) a	and manner as stat	ted.	
To T com	29	b. Signature and		and	manner state	d				se number			. Date signed (Mo		
		ia	LDCX	fa	lOd!				0.0	.M.E.		Oc	ctober 20, 200	7	
27	30	Name and addr Carol Allan,			pleted cause of Medical Ex		23a) 111 Penr	Street,	Baltin	nore, MD	21201				
State Registra		Date filed (Mo	Col Sear	2007	32 Regis	trar's Signatu	A P	OSAN P							
-															

5

OCME

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 34966

		I- For State Registrar	· Certificate o	f Death	Reg. N	lo.				
Physicia	_	Decedent's Name (First, Middle,Last)			Date of Death     Month Da		3. Time of Death			
Exami		Soft M. Voelker	~		October 27, 2	October 27, 2007				
		4a. Facility Name (if not institution, give street and num	iber)	4b. City, Town, or Location of Death		4c. County of Death				
		1924 Midland Road	Baltimore Cour							
Funeral		5. Social Security Number 6. Sex 7	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	_	M/DD/YYYY) 9. Birth Foreign	place (State or			
Director		115-91 -7,95 1VM 2 F	40 Yrs	Months Days Hours Min.	Jul17		intry) //(/)			
	H	Usual Residence of Decedent	70		Fory 11	// / /	7.0			
any	ľ	10a. State 10b. County	10c. City, Town or Loca	ition			10d. Inside City Limits			
* ·		MD Baltimore	Dundal	·k			1 Yes 2 No			
rylan ta-fs	윉	10e. Street and Number	· Salva act	10f. Zip Code	10g.	Citizen of What Coun	try?			
ith the Maryland 23a or 28a-f show notified at once.	Director	1924 Midla 1 Pa	1	212.22		11 SA				
rith th s 23a s noti		11. Marital Status 12. Was Dece	edent Ever in U.S. 13. W	as Decedent of Hispanic Origin? ( Sp	pecify Yes or No-	14. Race - Americ	can Indian, Black,			
r death wi or items must be	Funeral	1 Never Married 2 Married Armed For		Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.				
ter de		1 Yes 3 Widowed 4 Divorced If Yes, Give Year		Yes 2 No specify:		Specify: L.K.	1te			
ars af	ğ	15. Decedent's Education (Specify only highest grade	e completed) 16a. Decede	ent's Usual Occupation (Give kind of v		b. Kind of Business/Ir	ndustry			
2 hou "nai	홠	Elementary/Secondary (0-12) College (1-	4 or 5+)	most of working life. DO NOT use reti	red)	D1 6				
)36 hin 7 e. than	힏	12	l í	Pipe Fitter	1	Plumb	Ng			
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	17. Father's Name (First, Middle, Last)	/	18.Mother's Name	(First, Middle, Maid	den Surname)				
215 be file ntal H rked c	Be (	HENRY Miller Voei	1KeR	EVELVA	ERAT					
21 Suld B	ြ	19a. Informant's Name/Relationship (Type, Print )	19b. Mailir	ng Address (Street and Number or I	Rural Route Number	r, City or Town, State,	Zip Code)			
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  The mark of the marked other than "natural", or items 23a or 28a-fsh are or other traumatic event, the Medical Examiner must be notified at once		HENRY M. VOElker - FO	ther 162	5 Brookview	URd. Du	Nda/K, M	821222			
e, e, land land Healt litem		20a. Method of Disposition		osition (Name of cemetery,	Date / 2	Oc. Location - City or	Town, State			
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 Burial 2 Cremation 3 Removal fro	m State	eul/rema trail 16	1-79-17	Pa Itim	nce m			
Baltimo permit. Pag Department Important: injury or or		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22.	Name and Address of Facility	01/01/-1	454 TON FO	uneral Home,			
Balti permit. Departn Import injury		The Hall I have	$\mathcal{D}_{i}$	A 2134 11):11un	STRING	DA 1:12	1,22			
iysician		23a. Part I. Enter the disease, or complications that ca	used the death. Do not enter	the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval			
/Medical		failure. List only one cause on each line.	unshot Wound				Between Onset and Death			
Examiner			consequence of):							
		h								
	Jer		consequence of):							
	i.	cause. Enter Underlying Cause (Disease or injury that initiated	concernance of \;							
ed nsit	Ξxa	Due to (or as a consequence of):								
ecut and	d									
× = _		d.								
O, be exercian		d. UNPENDED AMENDED				22d Date of deliver				
3760, ficate be executed g physician and s the burial - transit	ואיר/Medical	IF FEMALE: 23c. If yes, of the state of the	outcome of pregnancy	Fetal death 3 Ectopic pregn	ancy	23d. Date of deliver				
(68760, certificate be exemple exemple of the certificate of exemple of the certificate of the certification of th	ואיר/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Live b	irth 2 F	etal death 3 Ectopic pregn	ancy					
Box 68760, death certificate be exite attending physician of for use as the burial -	ואיר/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, of 1 Live b	irth 2 F ant at time of death 5 (	Fetal death 3 Ectopic pregn		Month [	Day Year			
Box 68 e death certif the attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, of the pregnant in the past 12 months?	irth 2 F ant at time of death 5 0	Other (Specify)	23e. Did toba	Month I	Day Year the cause of death?			
Box 68 e death certif the attending ed for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	irth 2 F ant at time of death 5 0	Other (Specify)	23e. Did toba	Month I	Day Year			
Box 68 e death certif the attending ed for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	irth 2 F ant at time of death 5 0	Other (Specify)	23e. Did toba 1 Yes 24a. Was an	Month I cco use contribute to 2 No 3 Prol 24b. Were at	the cause of death? bably 4 Unknown			
Box 68 e death certif the attending ed for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	irth 2 F ant at time of death 5 0	Other (Specify)	23e. Did toba  1 Yes  24a. Was an autopsy perform	Month I  cco use contribute to 2 ✓ No 3 ☐ Prol  24b. Were at prior to death?	the cause of death? bably 4 Unknown utopsy findings available completion of cause of			
Records, P.O. Box 68 The law requires that the death certif cate has been signed by the attending page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  Contributing to	irth 2 F ant at time of death 5 0	Other (Specify)  e underlying cause given in Part I.	23e. Did toba  1 Yes  24a. Was an autopsy perform  1 Yes 2	Month I  cco use contribute to 2 ✓ No 3 ☐ Prol  24b. Were at prior to death?	the cause of death? bably 4 Unknown utopsy findings available completion of cause of			
Records, P.O. Box 68 The law requires that the death certif cate has been signed by the attending page 2 should be detached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  23c. If yes, of the past 12 months?  1 Unknown  2 Unknown  Contributing to the past 12 months?	irth 2 Fant at time of death 5 Cown  own  o death but not resulting in the	Other (Specify)  e underlying cause given in Part I.  26.Place of Death (Check	23e. Did toba  1 Yes  24a. Was an autopsy perform  1 Yes 2 (conly one)	Month I  cco use contribute to 2 No 3 Prol 24b. Were at prior to death? No 1 Y	the cause of death?  bably 4 Unknown  utopsy findings available completion of cause of es 2 No			
Records, P.O. Box 68 The law requires that the death certif cate has been signed by the attending page 2 should be detached for use as	e Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 Yes 2 No  1 Live b 4 Pregn g Unknown  27 Unknown  28 Unknown  29 Unknown  1 Hospital: 1 I	irth 2 Fant at time of death 5 Cown or death but not resulting in the	Other (Specify)  e underlying cause given in Part I.  26.Place of Death (Checkent 3 DOA Other, Nursi	23e. Did toba  1 Yes  24a. Was an autopsy perform  1 Yes 2  4 only one)	Month I  cco use contribute to 2 No 3 Prol  24b. Were at prior to death? No 1 Y	the cause of death?  bably 4 Unknown  utopsy findings available completion of cause of es 2 No			
Records, P.O. Box 68 The law requires that the death certif cate has been signed by the attending page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death  28a. Date	ant at time of death 5 (	26. Place of Death (Checkent 3 DOA Other 4 Nursion Injury 28c. Injury at Work?	23e. Did toba  1 Yes  24a. Was an autopsy perform  1 Yes 2 (conly one)	Month  Cco use contribute to  2 No 3 Prol  24b. Were at prior to death? No 1 Yesidence 6 Other	the cause of death?  bably 4 Unknown  utopsy findings available completion of cause of es 2 No			
Records, P.O. Box 68 The law requires that the death certif cate has been signed by the attending page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to  25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death  1  Natural 5 Pending 2  Accident Investigation 20ct 27,	ant at time of death 5 (and at time of death 5 (and at time of death 5 (and at time of death but not resulting in the content of injury (Day, Year) (Day, Year) (Day, Year) (2007 (0.128 hrs.)	26.Place of Death (Checkent 3 DOA Other, 4 Nursi Nijury 28c. Injury at Work?	23e. Did toba  1 Yes  24a. Was an autopsy perform 1 Yes 2  conly one)  ing Home 5 Re  28d. Describe hot Subject shot s	Month I  cco use contribute to 2  No 3 Prol 24b. Were au prior to death? 1  Yo  esidence 6  Othe winjury occurred self	the cause of death? bably 4 Unknown utopsy findings available completion of cause of es 2 No			
Records, P.O. Box 68 The law requires that the death certif cate has been signed by the attending page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	ant at time of death 5	26.Place of Death (Checkent 3 DOA Other, 4 Nursion of Injury 28c. Injury at Work?  1 Yes 2 No	23e. Did toba  1 Yes  24a. Was an autopsy perform  1 Yes 2  conly one)  28d. Describe hor Subject shot s  28f. Location (Stror Town, State)	Month  Coco use contribute to  2 No 3 Prol  24b. Were at prior to death?  No 1 Y  esidence 6 Other  winjury occurred self  eet and Number or Rite  (e)	the cause of death?  bably 4 Unknown  utopsy findings available completion of cause of es 2 No			
Records, P.O. Box 68 The law requires that the death certif cate has been signed by the attending page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	ant at time of death 5	26. Place of Death (Checkent 3 DOA Other, 4 Nursion of Injury 28c. Injury at Work?  1 Yes 2 No No reet, factory, office building, etc.	23e. Did toba  1 Yes  24a. Was an autopsy perform 1 Yes 2  3 only one)  ing Home 5 Re  28d. Describe hor Subject shot s  28f. Location (Stror or Town, State 1924 Midland R	Month  Coco use contribute to  2  No 3 Prol  24b. Were at prior to a death?  1  Your contribute to  2  Other winjury occurred self  eet and Number or Retele oad, Dundalk, MD	the cause of death? bably 4 Unknown utopsy findings available completion of cause of es 2 No er: Scene			
Records, P.O. Box 68 The law requires that the death certif cate has been signed by the attending page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to 25. Was case referred to medical examiner?  1  Yes 2 No  25. Was case referred to medical examiner? 1  Yes 2 No  27. Manner of Death 1  Natural 5 Pending Investigation 27. Accident Investigation 3 Suicide 6 Could not be determined (Specify)  29a. Certifier 1 Certifying Physician: To the beserver.	ant at time of death 5 (and at time of death 5 (and at time of death 5 (and at time of death but not resulting in the death but not resulting in the death but not resulting in the death but not resulting in the death but not resulting in the death but not resulting in the death of my knowledge, death occurrence of my knowledge, death occurrence of my knowledge, death occurrence of my knowledge, death occurrence of my knowledge, death occurrence of the death occurrence occurrence of the death occurrence	26.Place of Death (Check ont 3 DOA Other, 4 Nursi of Injury 28c. Injury at Work?  1 Yes 2 No reet, factory, office building, etc.	23e. Did toba  1 Yes  24a. Was an autopsy perform  1 Yes 2  conly one)  ing Home 5 Re  28d. Describe hor Subject shot s  28f. Location (Stroor Town, State 1924 Midland Red due to the cause(	Month  cco use contribute to 2 No 3 Prol 24b. Were at prior to a death? No 1 Y sidence 6 Othe winjury occurred self eet and Number or Re te) oad, Dundalk, MD s) and manner as sta	the cause of death? bably 4 Unknown utopsy findings available completion of cause of es 2 No er: Scene			
Records, P.O. Box 68 The law requires that the death certif cate has been signed by the attending page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to 25. Was case referred to medical examiner?  1 ✓ Yes 2 No  25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident Investigation 3 ✓ Suicide 6 Could not be determined (Specify)  29a. Certifier 1 Certifying Physician: To the besis and manners and	ant at time of death 5	26.Place of Death (Checkent 3 DOA Other;  1 Yes 2 No reet, factory, office building, etc.	23e. Did toba  1 Yes  24a. Was an autopsy perform 1 Yes 2  conly one)  Ing Home 5 Re 28d. Describe hot Subject shot s  28f. Location (Str or Town, Stat 1924 Midland R  Ind due to the cause( at the time, date an	Month  Coco use contribute to  2 No 3 Prol  24b. Were au prior to death?  1 Yo  2sidence 6 Othe winjury occurred self  eet and Number or Re (e) oad, Dundalk, MD s) and manner as sta d place, and due to ti	the cause of death? bably 4 Unknown utopsy findings available completion of cause of es 2 No er: Scene ural Route Number, City ted. he cause(s)			
Box 68 e death certif the attending ed for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	ant at time of death 5 (and at time of death 5 (and at time of death 5 (and at time of death but not resulting in the own of death but not resulting in the own of linjury 28b. Time of linjury 28b. Time of FOUND: 2007 (and at time of linjury - At home, farm, stress of linjury - At home, farm, str	26.Place of Death (Checkent 3 DOA Other; 1 Yes 2 No reet, factory, office building, etc.  29c. License number	23e. Did toba  1 Yes  24a. Was an autopsy perform 1 Yes 2  conly one) ing Home 5 Re  28d. Describe hor Subject shot s  28f. Location (Stror Town, State 1924 Midland R  id due to the cause( at the time, date an	Month  Coco use contribute to  2 No 3 Prol  24b. Were at prior to a death?  No 1 Y  esidence 6 Other  winjury occurred self  eet and Number or Rele) oad, Dundalk, MD  s) and manner as stad diace, and due to the self.	the cause of death? bably 4 Unknown utopsy findings available completion of cause of es 2 No er: Scene ural Route Number, City ted. he cause(s)			
Records, P.O. Box 68 The law requires that the death certif cate has been signed by the attending page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to 25. Was case referred to medical examiner?  1 ✓ Yes 2 No  25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident Investigation 3 ✓ Suicide 6 Could not be determined (Specify)  29a. Certifier 1 Certifying Physician: To the besis and manners and	ant at time of death 5 (and at time of death 5 (and at time of death 5 (and at time of death but not resulting in the own of death but not resulting in the own of linjury 28b. Time of linjury 28b. Time of FOUND: 2007 (and at time of linjury - At home, farm, stress of linjury - At home, farm, str	26.Place of Death (Checkent 3 DOA Other;  1 Yes 2 No reet, factory, office building, etc.	23e. Did toba  1 Yes  24a. Was an autopsy perform 1 Yes 2  conly one) ing Home 5 Re  28d. Describe hor Subject shot s  28f. Location (Stror Town, State 1924 Midland R  id due to the cause( at the time, date an	Month  Coco use contribute to  2 No 3 Prol  24b. Were au prior to death?  1 Yo  2sidence 6 Othe winjury occurred self  eet and Number or Re (e) oad, Dundalk, MD s) and manner as sta d place, and due to ti	the cause of death? bably 4 Unknown utopsy findings available completion of cause of es 2 No er: Scene ural Route Number, City ted. he cause(s) onth, Day, Year)			
Records, P.O. Box 68 The law requires that the death certif cate has been signed by the attending page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending lnvestigation and manner solve determined  29a. Certifier of Could not be determined  29a. Certifier of Certifying Physician: To the besis and manner solve and ma	ant at time of death 5	26. Place of Death (Checkint 3 DOA Other4 Nursuff Injury 28c. Injury at Work?  1 Yes 2 No  reet, factory, office building, etc.  29c. License number  O.C.M.E.	23e. Did toba  1 Yes  24a. Was an autopsy perform 1 Yes 2  conly one) ing Home 5 Re  28d. Describe hor Subject shot s  28f. Location (Stror Town, State 1924 Midland R  id due to the cause( at the time, date an	Month  Coco use contribute to  2 No 3 Prol  24b. Were at prior to a death?  No 1 Y  esidence 6 Other  winjury occurred self  eet and Number or Rele) oad, Dundalk, MD  s) and manner as stad diace, and due to the self.	the cause of death? bably 4 Unknown utopsy findings available completion of cause of es 2 No er: Scene ural Route Number, City ted. he cause(s) onth, Day, Year)			
Records, P.O. Box 68 The law requires that the death certif cate has been signed by the attending page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to 4 Pregn g Unknown  Part II. Other significant conditions contributing to 25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending Investigation 22 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  29a. Certifier (Check only one) 2 Medical Examiner: On the basis and manner s  29b. Signature and title of certifier	ant at time of death 5	26.Place of Death (Checkent 3 DOA Other; 1 Yes 2 No reet, factory, office building, etc.  29c. License number	23e. Did toba  1 Yes  24a. Was an autopsy perform 1 Yes 2  conly one) ing Home 5 Re  28d. Describe hor Subject shot s  28f. Location (Stror Town, State 1924 Midland R  id due to the cause( at the time, date an	Month  Coco use contribute to  2 No 3 Prol  24b. Were at prior to a death?  No 1 Y  esidence 6 Other  winjury occurred self  eet and Number or Rele) oad, Dundalk, MD  s) and manner as stad diace, and due to the self.	the cause of death? bably 4 Unknown utopsy findings available completion of cause of es 2 No er: Scene ural Route Number, City ted. he cause(s)			

ORIĞINAL

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 2:04 P ERWIN (NMN) WEISSER OCTOBER 26, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil Union Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours 1XM 2□F Director 212-56-8258 June 27, 1940 Germany Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County a or 28a-f show t be notified at 1 Yes 2 No Director Maryland | Cecil Elkton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a 410 North Street 21921 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [★No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: δ 3 Widowed 4 Divorced White Completed er than "natur the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Mechanic Automotive Item 27 Is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Erwin J. Weisser Louisa (unknown) Herlan ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara Weisser / Wife 410 North St., Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any Injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hilltop Service Corp 10-31-07 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature/of/Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Errer the disease, or complicative that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a corr equence of): /Medical Examiner Du-lo (or as a consequen e of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician. The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) 1 ☐ Yes 2 💢 No Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 3□ DOA 1 🔲 Inpatient 2 ☐ ER/Outpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1∏Yes 2∏No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EIKUR, MD 21921 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	Marylan			nt of He		ind Me		giene 20	07	34968
	Physici	an	1. Decedent's Name (First, Middle, Last	)							2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Medic		Jerry Rhonle	s Workm	an		45 005	Town and			)ctober	24, 20	07	12:33 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give 412 Bonham Ro		er)			Town, or L	ocation o	t Death		Harf		
	Funeral		5. Social Security Number 6. Se		Age (In yrs.	last birthday)		r 1 Year	If Under 2		B. Date of Birth	h		place (State or Foreign
	Director		236-60-8907	ØM 2□F	70	Yrs.	Months	Days	Hours	Min.	(Month, Da)	1937		Virginia
	pu 🖈		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation							Od. Inside City Limits
	the Marylen 28a-f ahow	ō			100.01	_								1 ☐ Yes 2 ☑ No
	28a-	rect	Maryland Harfo  10e. Street and Number	ord		Ų	oppa 10f. Zi	Code				10g. Citizen of V	What Cour	ntry?
	h with	Funeral Director	412 Bonham Road					210	085			USZ	A	
	deatl	ner	11. Marital Status	12. Was Decede Armed Force		.S. 13.	Was Dece			gin? (Spec	ify Yes or No- ican, etc.)			can Indian, etc.
36	72 hours after death with the Marylend natural', or items 23a or 28a-f ahow ilsa Exandras nuat be notified at	by Fu	1 Never Married 2/2 Married	1X∑Yes 2[ If Yes, Give	□No		1 ☐ Yes		Specify:			Specify	y:	
21215-0036	hours fural'	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Date	s:	16a. Dece	dent's Usu	al Occupat	ion			16b, Kind of B		ite dustry
15	nin 72 n "na Nedic	Completed	(Specify only highest grad	le completed) College (1-40	or 5+\	(Give	kind of we	ork done du ise retired)	ring most	of workin	7	Maryla	nd	
212	filed within Hygiene. other then "	E C	12	College (1-40			Supe	rviso	r			Transi	c Aut	hority
	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)					1	8. Mothe	r's Name	First, Middle.	Maiden Suman	10)	
Maryland	should I	၉	Alec (unk) Work			101-11-11	4					Steven		Codel
Mai	d2 sh th and 7 is n traum		19a. Informant's Name/Relationship (T)  Judy M. Workman				-				, MD 2	r, City or Town, 1085	State, ZIF	Code)
	Heall tem 2		20a. Method of Disposition	11220	20b. P	Place of Dispo	sition (Na	me of		Da		20c. Location ·	City or To	own, State
OE	Pages nent of int: If It		1 ☐ Burial 2 ☑ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)		ite	emetery, cres .1top S			1	10-2	9-07	Towson	. Mar	vland
Baltimore,	교투론를 .		21. Signatur vol. Funeral Service Licens		- 1	2:	2. Name a	nd Address	of Facility	v	e, P.A			
Ø	Depermine the permine	Alwy I llon	aston	ut	- $+$ $1$	317	Cokesi	oury	Rd.,	Abing	don, MD	2100	19	
8760,	beath certificate be executed estending physician and estending physician and for use as the burial-transit	Icai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Oue to (or Due to (or c.		uence of): uence of):		30 01 07 11 13						Approximate Interval Between Onset and Death
P.O. Box 68	0 0	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnan 9 □ Unknowr	n 2 ∏ Feta t at time of d	Ideath 3	⊒Ectopic p ☐ Other (s						ate of deliver	ery Day Year
	88 20 99	þ	Part II. Other significant conditions co	ntributing to deat	h but not res	utting in the u	nderlying	cause giver	n in Part I.		23e. Did to	_		the cause of death?
Records,	aw 2 sb	Completed									24a. Was autop perfo 1 ☐ Yes	maed?	prior to co death?	opsy findings available ompletion of cause of
ita	lan: 'rtifica	BeC	25. Was case referred to medical						26. Place	of Death	(Check only o			
of Vital	ding Physician: The I h. After this certificate ha funeral director, page	To	TES 45 NO			ER/Outpatie			4 🗆 Nu			dence 6 Oth		fy)
2	ing P		27 Manner of Death  1 Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time o Injury		28c. Injury			3d. Describe I	now injury occur	red	
Division	Attending r death. ector: Afte by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of	Injugy - At h	ome farm st	M facto		es 2 🔲 I		8f Location (	Street and Numl	her or Rur	al Route Number,
Ο̈́	effer Direct	Certification:	4 ☐ Homicide determined	building,	etc. (Specif	(y)	,000, 1200	, o			City or Tox			
	To the Hospitel or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier Check only one) Certifying Phy		s of examina									
	To th Within To th COMP	Me	29b. Signature and title of certifier				25	c. License	number	)		29d. Date signe	d (Month,	Day, Year)
	1 1		Day _					05	137	1		10/24	1101	1
)	07		30. Name and address of person who co	7	of death (Item	n 23a) (Type,	Print)	1-11	DJ.	0	rie 20	n c-1+	20-0-	1, Ma 2031
	1		31. Date filed (Month, Day, Year)	2011 32 Bea	istrar's Signa	ature d	m	TES/A/	0101	17 71	NEU	V 1801	, v vara	1 200
	Sta Registi		OCT 9 1 700	7	Sa S	A April	afin s							

WORKMAN

State of Maryland / Department of Health and Mental Hygiene 2007 For State Registra Certificate of Death 3. Time of Death 2. Date of Death M A OF 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Bel Air 1801 Ruffs Mill Road Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Days Months Hours **Funeral** 1 M 2X F Nebraska Yrs. 1902 July 1, 105 213-28-6550 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State Health and Mental Hygiene. Item 27 is marked other than "naturel", or Iteme 23a or 28a-f ehow other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Bel Air Maryland | Harford Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21015 1801 Ruffs Mill Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Maryland 21215-0036 þ White 3 XWidowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) 72 College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sara Jane Anders Andrew Jackson Anders ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1801 Ruffs Mill Rd., Bel Air, MD 21015 Pages 1 and 2 ment of Health a ant: If item 27 is Blanche Andrews / Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Baltimore, 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5 permit. Page Depertment o Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Grdn 11-3-07 Bel Air, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sagrentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires thet the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. Physician/Medical as the IF FEMALE 23d. Date of delivery 950 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day Year Month in the past 12 months? ŏ 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached fo o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Be Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy hes 2-1 No 1 ☐ Yes certificete or Attending Physician: director, 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Tes € No 1 Inpatient ဥ 28d. Describe how injury occurred within 24 hours efter deeth.

To the Funeral Director: After thi
completely filled in by the funeral. 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 27. Manner of Death Injury at Work? Medical Certification: Natural 5 Pending 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 | Homicide To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month. Day, 29c. License number 29b. Signature and title of certifier Completed cause of death (Item 23a) (Type, Print) Falls 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Registrar

DHMH 17 Rev 1/2001

State

Square Drive, Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ritter

OCT3 1

31. Date filed (Month, Day, Year)

9000 Franklin 32. F. gistrar's Signature

			r reduce ry		epartment of Health and	•	•	
			1 - For State Registrar		Pertificate of Death		2007	34972
		10	Negistrar  1. Decedent's Name (First, Middle, Last)		Dertificate of Death	Reg. I	NOC O O I	3. Time of Death
- 1	Physic			deline Webb		Month [	Day Year	3. Fille of Dealit
	/Medi Exami		4a. Facility Name (If not institution, give stre		4b. City, Town, or Location of Deatl		4c. County of Death	1 7
· All			Good Fameritan Hos	pital	Baltimore, M.	aufand		
	Funeral		5. Social Security Number 6. Sex 1	7. Age (In yrs. last birthe	Monthe Dave Hours Min	8 Date of Birth (Month, Day, Yea	ar) 9. Birthp	lace (State or Foreign
	Director		Usual Residence of Decedent	2197 76 Yr	S.	2-27-1	1931	WV
	land ow It		10a. State 10b. County	10c. City, Town o	or Location		1	0d. Inside City Limits
	Mary -f sh	ţo	MD Baltimoi	Ce Balt	more			1 ☐ Yes 2 ☐ No
	h the or 28a o noti	irec	10e. Street and Number	C Dail	10f. Zip Code	10g. (	Citizen of What Coun	itry?
	ours after death with the Marylan ral", or items 23a or 28a-f show Examiner must be notified at	Funeral Director	5 Broth ( t.	Ant. 210	21221		18A	
	r dea	Inel	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - America Black, White, e	
36	s afte	by Fi	1 Never Married 2 Married	1 Yes 2 YNo If Yes, Give	1 ☐ Yes 2 ☐ No Specify:	o / 110an, 010./	Specify: 1	10
21215-0036		q pa	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Education	Year or Dates:	ecedent's Usual Occupation	101	wit	
5	d within 72 ha giene. r than "natu the Medical	Completed	(Specify only highest grade co	mpleted) (C	ecedent's Osual Occupation Give kind of work done during most of wor fe. DO NOT use retired)	king 16b.	Kind of Business/Ind	lustry
212	filed withi Hygiene. other than ent, the M	E	Elementary/Secondary (0-12)	College (1-4or 5+) "	UlAitee.bb		Hospita	1. 41
b	al Hygid I other vent, tl	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, Maid	en Surname)	7
<u>ya</u>	should be filed and Mental Hygi s marked other umatic event, ti	P	Hobert PayNe		Lula	Adair		
Maryland			19a. Informant's Name/Relationship (Type.	Print) 19b. N	lailing Address (Street and Number or Ru	iral Route Number, City	y or Town, State, Zip	Code)
	es 1 and 2 of Health a item 27 is		Brenda / 1emann -	daughke 74	49 School HVENUE	, Dundali	K, Mb.	21222
Baltimore,	ages of the state		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo		isposition (Name of crematory or other place)		Location - City or To	3
Ę	permit. Page Department of Important: If any Injury or once.		4 □Donation 5 □ Other (Specify)	Bayvic	W Crematory 10-3	30-07	Baltimore	MD Home
Ba	Depa Impo any l		21. Signature of Funeral Service Licensee	<u> </u>	22. Name and Address of Facility $\mathcal{B}_{\ell}$	adley - Asi	LON FUNC	eral Home
	1 10-100		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can	ons that caused the death. Do not	enter the mode of dying such as cardiac	SD TING &	20, 212	Approximate
	Physician		Immediate Cause (Final	ause on each line.	4	or respiratory arrest,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence /:	Taillue_			Wells
5	Examiner		Companied by the constitutions	Lucho	dis			30 years
	P #	Examiner	Sequentially list conditions, if an, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a computence of):	1 0			5
	recute and -trans	хаш	that initiated events resulting in death) Last	Heput	THE CONTRACTOR			Dongen
760,	be execu ician and burial-trar	calE		Due to (or as a consequence of):				I
687	res that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit		d			·		
Вох	certificat nding phy use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. I	f yes, outcome pf pregnancy			22d Date of deliver	
Ď.	death e atten	icial	in the past 12 months?	☐Pregnant at time of death	3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliver Month	Day Year
P.0	t the by the ache	hys	9 □ Unknown	Unknown				
	The law requires that the tee has been signed by the rage 2 should be detache	by P	Part II. Other significant conditions contribu	iting to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco	use contribute to the	e cause of death?
ord	w require been signations been signatured b	ed	Thure &	epsis		1 ☐ Yes	2No 3□ Proba	ably 4 □Unknown
Records,	law r as be	Completed	tent ell	end-Failure		24a. Was an autopsy		sy findings available
E		ا ا	/		_	performed?	death?	npletion of cause of 2□ No
Vital	ysician: The law is certificate has b director, page 2 s		25. Was case referred to medical examiner?			h (Check only one)		
o	> .20 0	2	1 ☐ Yes 2 ☐ No Hospi 27. Manner of Death 23	Nopatient 2 ER/Outpa		ome 5 Residence		)
Ö	ling Affer une	io	Vatural 5 Pending	Ba. Date of Injury (Month, Day Year) 28b. Tim- Injur	y Work?	28d. Describe how inj	ury occurred	
Division	Atten deat ctor: y the	licat	a Electrical CE Could not be	Be. Place of injury - At home, farm,		28f. Location (Street a	and Number or Ruml	Pouto Mumbay
Dis	al or / after I Dire d in b	Certification:	4 ☐ Homicide determined	Se. Place of injury - At home, farm, building, etc. (Specify)	onest, radiory, onloc	City or Town, Sta	tria Number of Hurar te)	Houte Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier  (Check only 2 Medical Examiner:	n: To the best of my knowledge, de	eath occurred at the time, date and place,	and due to the cause(	(s) and manner as sta	ated.
	the H iin 24 the Fi iplete	Medical	one) 2   Medical Examiner:	On the basis of examination and/o and manner stated.	r investigation, in my opinion, death occur	red at the time, date a	nd place, and due to	the cause(s)
	To T	Σ	29b. Signature and title of certifier	1111	29c. Lipense number	29d. D	ate signed (Month, P	Pay, Year)
	4		· X auxou splly	4/4	4/280		10/29/0	7
	11		30. Name and address of person who comple	ted cause of death (Item 23a) (Typ	e, Print)	10 11	11.	1
	Sta	2	31. Date filed (Month, Day, Year)	32 Hegistrar's Signature	imarila Hoffical	) Bultim	on Mary	Kand 21239
F	Sta Registra	~	OCT 3 1 2007	Broken & la	Carles	/		/

DHMH 17 Rev 1/2001

			Please	Type or Pri	nt in E	Black In	delible lnk.	Ensure /	All Copies	s Are L	egible.	
		For		State of Ma	arylan		artment of F		Mental Hy		0007	01.070
		1 - State Registrar				Ce	rtificate of	Death		Reg. No.	2007	34973
Physicia	an		ne (First, Middle, Las			•			2. Date of D Month	Day	Year	3. Time of Death
/Medic			m Anthon	y Weining	ger,	Sr.	Ab City Town o	r Location of Deat	DCTUBE		2007 County of Death	00:41 T M
Examin	er	1	AMARITA		PITI	AL		LTIMOR	_	40.0	N/A	Č.
Funeral		5. Social Security N	lumber 6. S	ex 7. Ag	e (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	. 8. Date of B	irth	9. Birth	place (State or Foreign
Director		216-30-0 Usual Residence of	315	<b>X</b> M 2□F	73	Yrs.	World Days	110010	09-30-	-1934	Mary	Tand
/land low at		10a. State	10b. County	· · · · · ·	10c. City	, Town or Lo						10d. Inside City Limits
a-f sh	ctor	Maryland	N/A			E	Baltimore					1 XYes 2 No
ith the	Director	10e. Street and Nu	mber				10f. Zip Code			10g. Citiz	en of What Cou	ntry?
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	eral		nview Ave					213			U.S.A.	
ter de	Funeral	11. Marital Status 1 □ Never Marr	ried 2 Marnied	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔯 I		S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or N to Rican, etc.)	0- 1	<ol> <li>Race - Americ Black, White,</li> </ol>	
al', or	Ď	3 X Widowed		If Yes, Give Year or Dates:			1 ☐ Yes 2 🖾 No	Specify:		,	Specify: Whi	te
72 ho	Completed	(Spec	15. Decedent's Ec	ucation de completed)		16a. Dece	dent's Usual Occup	ation during most of wo	rkina	16b. Kin	d of Business/In	dustry
within	mp	Elementary/Seco		College (1-4or 5	5+)	life.	DO NOT use retired	d) -	9		-41-7-1	Ct1 C.
filed hygie	රි	17. Father's Name	(First, Middle, Last)			316	<u>eel Worke</u>	18. Mother's Na	ne (First, Middle			Steel Corp
lental Pental rked c	To Be	William	J. Weini	nger					Clarke		,	
2 shou and N is ma		19a. Informant's Na	ame/Relationship (7	ype. Print)		19b. Maili	ng Address (Street			ber, City or	Town, State, Zip	Code)
and lealth m 27 her tr				- Daught		1	Mary Ave	nue Bal			land 212	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			☐Cremation 3 ☐	Removal from State	0	emetery, cre	osition (Name of matory or other plac V Redeeme		Date 01/2007	]	ation - City or To	
artme artme ortant injury		_	5 Other (Specify uneral Arvice Licen		1103		2. Name and Addre				arford F	Maryland Moad
perm Depa impo any i		De Charle	e I Mi	in A			eonard J.	•	D.	altimo	ore, Mar	yland 21214
		23a. Part1. Enter to	the disease, or comp	plications that caused one cause on each lin	the death					arrest,		Approximate Interval Between
Physician		Immediate Cause ( disease or conditio	(Final	2	SIS	^		RATOR		IIWR	E	Onset and Death
/Medical Examiner		resulting in death)		Due to (or as	a consequ	ence of):			, , ,			
Examine	_	Sequentially list co	nditions,	b. Due to (or as	TIC		DOSIS					
uted I Insit	Examiner	Sequentially list confiant, leading to incause. Enter Under Cause (Disease or	erlying injury	•		,	2 PERI	PUERD	1 VASC	01 ( 0	RNICER	+r E
be executed cian and curial-transit		that initiated events resulting in death) L	Last	C. Due to (or as			2 . 010	· recixin	0 1120	u ciri	14 91307	13 C
ficate be physicia s the bur	Physician/Medical			d								
death certificate that attending physical for use as the b	Med	IF FEMALE:		00 - 1/	,				-			
eath c attenc for us	sian/	23b. Was decedent in the past 12	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3[	☐Ectopic pregnancy ☐ Other (specify)	,		23	Bd. Date of delive Month	ery Day Year
the d	ysic	1 □ Yes 2 □ 9 □ Unknown		9□Unknown	tille of de	salli SL						
	by PI			ontributing to death be				en in Part I.	23e. Did	tobacco us	e contribute to t	ne cause of death?
equire sen sig	ted k	MYOC	ARDIAL	9NF ARTER	AR	CTIC	$\sim$		1 🗆	Yes 2□	No 3 ☐ Prot	pably 4 Onknown
has be	Completed	CORO	NARY	ARTER	4	DISET	ASLE		24a. Was	psy	24b. Were auto	psy findings available mpletion of cause of
r: The icate I									perf 1∐ Yes	ormed? 2 2 No	death? 1 ☐ Yes	2 No
siciar certif	Be	25. Was case reference examiner? 1 ☐ Yes 2 ☐		Hospital:	O [] [		otho	26. Place of Dea				
g Phy er this eral d	<u>ا</u> ت	27. Manner of Deatl		1 Inpatie	ry	ER/Outpatier 28b. Time o	IL 3 DOA	4 ☐ Nursing F	lome 5 ☐ Res 28d. Describe		Other (Specif	y)
ath. ath. r: Aft	atio	Natural 2 ☐ Accident	5 ☐ Pending investigation	(Month, Day	(Year)	Injury		Yes 2 □ No				
or Atter ter de lirecte n by ti	<u>≅</u>	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injubulding, etc.	ry - At hor c. (Specify	me, farm, str	eet, factory, office		28f. Location ( City or To	Street and wn, State)	Number or Rura	I Route Number,
pital o	<u></u>	29a. Certifier	1 Destituing Phy	rejejon: To the best	of mu know	ulodao deat	h accurred at the tim	an data and also				
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	Medical Certification:	(Check only one)	2 Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examinat	ion and/or in	vestigation, in my o	pinion, death occ	e, and due to the urred at the time	, date and	and manner as s place, and due to	tated. the cause(s)
To the within To the complete	Me	29b. Signature and	title of certifier	. /			29c. License	number		29d. Date	signed (Month,	Day, Year)
			Yhawat	MD			RE	ESODO		OCTO	BER 2	8 2007
1		0		ompleted cause of de	eath (Item	23a) (Type,	Print)					
		RUSHAW 31. Date filed (Mont	DHAWA	32#Registra	LOC	H RA	VEN BL	ND, B	ALTIMO	DRE	, MD	21239
Stat Registra		On Date med (WORL)	OCT 3 1 20	07 La Sacra	ar a digital	& An	and o					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day PM Aldeize Nery Walker October 23, 2007 12:37 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6309 Tuckerman Lane Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min Director 563-23-8824 59 September 16, 1948 **Brazil** Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6309 Tuckerman Lane permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must 20852 11 / United States 14. Race - American Indian, Funeral Brazil 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 😿 If Yes, Give Year or Dates: 2 ▼ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No \$ Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Vivaldo Suarez De Souza Maria Hortensia Nery Roberto 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William G. Walker / Husband 6309 Tuckerman Lane, Rockville, Maryland 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 0 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 27, 2007 Montgomery Crematorium Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501 21. Signatu of Funeral Service Ligensee M01473 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Progressive Brain Tumor 12 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed: 2**X** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

20 State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Victor Priego, M.D.

29a. Certifier

mynmo

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

D23308

October 23, 2007

6420 Rockledge Drive, #4100, Bethesda, Maryland 20817

29c. License number

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours after death. after death Director: e Funeral

funeral director, page 2 should Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29b. Signature and title of certifier D40854 MD

29d. Date signed (Month, Day, Year)

10/29/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

Rischer Durig 31. Date filed (Month Day, Year) 32. Registrar's Signature

St Paul 227

Bultinore

21202

Year

5:45P <sup>™</sup>

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10e per inf State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Month 27, <u>Bernadette Rene' Yelverton</u> Oct. 2007 /Medical 2:50A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TOWSON
Inder 1 Year | If Under 24 Hrs.
Days | Hours | Min. Gilchrist Hospice Center Baltimore 5. Social Security Number If Under 1 9. Birthplace (State or Foreign Country)
NY 8. Date of Birth (Month, Day, Year) 11.01.1949 Funeral . Age (In yrs. last birthday) 1 M 2 F Months **Director** 57 104.40.0968 Usual Residence of Decedent with the Maryland 10a. State show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** MD Howard Ellicott City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4811 Shady Path Apt. 21043 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 To No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bank Officer Finance 17. Father's Name (First, Middle, Last) Charles 18. Mother's Name (First, Middle, Maiden Surname) Be Roscoe Yelverton Wilhelmina Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Los Angeles,
612 S. Cochran Avenue Apt. 307 90036 19a. Informant's Name/Relationship (Type. Print) CA Bernell Hollis/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Scremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 10.30.07 Beltsville, MD 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licensee 10144 Alternatives 8717Green Pastures Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician GASTRIC LANCER *veas*s /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate sause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed to be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen page 2 s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 24a. Was an autopsy performed? Yes 2 No certificate 1□ Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 555 W. Towsartown, Blad/Bulto MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

roulkner MD.

31. Date filed (Month, Day, Year)

0C

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Ì	
	Physician
	/Medical
	Examiner
	_xaiiiiioi
_	· · · · · · · ·

**Funeral** Director death with the Maryland

item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director Funeral filed within 72 hours after Hygiene. δ Completed and Mental I Be မ Health tem 27 i Pages 1 Department of Important: If it any Injury or o

Baltimore, Maryland 21215-0036

Box 68760.

o

۵.

Division or Vital Records,

Physician:

1 and 2 should be

**Physician** /Medical Examiner

Examine use as the burial-tran physician Physician/Medical signed by the a d be detached f à Completed page 2 has certificate funeral director Be ို this Certification: death. after death the filled in by within 24 hours at To the Funeral D completely filled i

2. Date of Death 1. Decedent's Name (First, Middle, Last) Day SEPTEMBER 24, 2007 7:20 P.M MARY JANE ANDREWS 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death ALLEGANY SINCERELY YOURS PERSONAL CARE HOME CUMBERLAND If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 ☐ M 2 XF 16,1922 216-18-1524 WEST VIRGINIA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 TNo MD **ALLEGANY** CUMBERLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 30 POTOMAC STREET 21502 U.S.A. 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No 3 ☐ Widowed 4 X Divorced WHITE 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER HOME 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ESTELLA A. KITZMILLER CHARLES L. KIBLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROUTE 1, BOX 22, WILEY FORD, WV ROLAND BOLYARD / NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SUNSET MEMORIAL PARK 09/28/2007 CUMBERLAND, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, 21502 Approximate Interval Betweer Onset and Deatl 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause unleach line. Immediate Cause (Final els disease or condition resulting in death) Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one) tersonal Care Home Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 Tyes 2 No 2 ER/Outpatient 3□ DOA 6 Other 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Watural 28b. Time of 28d. Describe how injury occurred Injury at Work? Injury 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) . Name and address of person who 500 31. Date filed (Month, Day, 32/Registrar's Signature

DHMH 17 Rev 1/2001

5

Registrar

State

Year)

			For State Registrar	State of Man	/lanc		artment o tificate d			d Menta		iene 0	07	349	78
F. 3	Physicia	an	Decedent's Name (First, Middle, La	(st)	BA	150	2			Mo	te of Deat onth	Day	Year 7007	3. Time of	
	/Medic Examin	_	4a. Facility Name (If not institution, gin	Road				٠ 🛧	Tun	2 2		4c. Count	y of Death	elt	
**	Funeral Director		723-09-0950	1MM 2□E	79	Yrs.	If Under 1 You Months Da		f Under 24 Hours	Min. (Mo	te of Birth onth, Day, 0. 22	,1928	Cour	lace (State or eville	
	Maryland a-f ehow		Usuaf Residence of Decedent  10a. State 10b. County  MD Garret		Oc. City,	Town or Lo							1	0d. Inside Cit	
	with the	<u>a</u>	10e. Street and Number				10f. Zip Coo				1	0g. Citizen of		ntry?	
39	filed within 72 hours after death with the Maryland Hygiene ther than "naturel", or iteme 23s or 28s-f show ent, the Medical Examinar must be notified at	by Funeral	468 Pritts Road  11. Marital Status  1 □ Never Married 2 □ Married  3 🖫 Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	r in U.S		ZI Was Decedent f Yes, specify ( 1 ☐ Yes 2 🛣	Cuban,	anic Origin	? (Specify Ye Puerto Rican,	etc.)	14. Ra	SA ce - Americ ck, White, fy: Whi	etc.	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atto Depertment of Health and Marial Hygiens. In Inciporant: If Item 27 is marked other then "naturel", or important: If Item 27 is marked other then "naturel", or any injury or other treumatic event, the Health Example place.	Completed	15. Decedent's E (Specify only highest gi			(Give	dent's Usual Oo kind of work do DO NOT use re	one dur. stired)	ring most of			Reta	il	dustry	
d 21	illed w Hygiel other ti	Be Col	17. Father's Name (First, Middle, Las	1)		Self	employe	-				Auto S. Maiden Suma			
ylan	should be ind Mental marked o	ToB	Loman Baker				(0)			alie E		City on Francisco	Chan Zie	Codel	
	and 2 sh ealth and n 27 ie m		19a. Informant's Name/Relationship Sandra Kay Bake1				ng Address (St. N. Mai						6726	(000)	
Baltimore,	Pages 1 ar		20a. Method of Disposition  1 🗓 Buriat 2 □ Cremation 3 ( 4 □ Donation 5 □ Other (Spec	☐Removal from State	ce	metery, crei	sition (Name of matory or other lemoria	place)	. 1	Oct.	27	20c. Location Keyse			
3alti	permit. Page Depertment ( Important: If any injury or		21. Signature of Funeral Service Lice	ensee	_	22	2. Name and A		S (2007)			eral H		- 4 -	
(ca)	Physician		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	nplications that caused the cone cause on each line.  Metast	1	. Do not ent	85 S. er the mode of Blace	dying,	such as ca	rdiac or resp	ratory arr		26	7 2 6 Approximate Interval Bety Onsets and I	veen
	Medical Examiner  physicien end the burial-transit	lical Examiner	resulting in death)  Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a condition of the cond	onsequ	ence of):									
P.O. Box 68	ne death certific the attending p hed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. tf yes, outcome of 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tirn 9 ☐ Unknown	∃Fetal	death 3	Ectopic pregn Other (specif					l l	ate of deliv	-	/ear
rds, P.	w requires that the state of th	Ď	Part II. Other significant conditions	contributing to death but r	not resu	ilting in the u	nderlying caus	e given	in Part f.	2		bacco use cor es 2□No	ntribute to t		eath? Jnknown
Vital Records,	The law receive has bee page 2 shor	Completed								_	4a. Was a autops perfor ☐ Yes	Sy	. Were auto prior to co death? 1 \( \subseteq \text{Yes}	opsy findings ompletion of c 2 No	available ause of
	scertificete firector, pag	To Be	25. Was case referred to medicaf examiner?  1 Yes 25 No	Hospital:	2 🗆	ER/Outpatie	nt 3 DOA	Other:		f Death (Che	~	ne) ence 6 □0	ther (Speci	fv)	
Division of	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificete his completely filled in by the funeral director, page		27. Manner of Death  1 Naturat 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Y		28b. Time o Injury		Injury a Work?	at	28d. D		ow injury occu		,,	
Divis	To the Hospital or Attend within 24 hours after death To the Funeral Director: . completely filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine				reet, factory, of	fice			ocation (S ity or Tow	treet and Nun n, State)	nber or Rur	al Route Num	ber,
	Hospit 24 hour Funera etely fille	edicai (	29a. Certifier Gertifying F (Check only one) Gertifying F	Physicien: To the best of a miner: On the basis of ea and manner state	caminat	wtedge, deat ion and/or in	h occurred at to estigation, in	he time my opir	, date and non, death	place, and du occurred at t	ie to the d he time, d	ause(s) and r late and place	nanner as , and due	stated. to the cause(s	)
	To the To the compl	Me	29b. Signature and title of certifier	· Rayo	0_	R	29c. Li	cense r	number 26	154	, 2	29d. Date sign	led (Month)	Day, Year)	
•	7		30 Name and address of person wh	completed cause of dea	th (Item	23a) (Type,	Print)	C	An	× 1	/	Jakl.	and	MD	
150	Sta Registi		31. Date filed (Month, Day, Year)  OCT 3 1 2	32 Registrar's	Signal	Hure Ap	rela!			-5 <b>U</b> '		, , , ,	· •	215	370

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** ELLEN BRANSON BYRD 10:40 A M 2007 Oct. 15. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Brighton Garden If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 1 F 22,1923 Washington DC 84 Director 579-26-3365 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or Items 23a or 28a-f show Idical Examiner must be notified at 1 XYes 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5005 Nahant ST 20816 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any linjury or other traumatic event one. Be James Taylor Branson Marie Quill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kevin B. Byrd 5005 Nahant ST Bethesda, Maryland 20816 Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate Of Heaven Cem. Heaven Cem. Oct. 19,07 Silver Spring, Md. 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service License 5130 Wisconsin Ave. NW Washington, DC 20016 e, or complication, thit caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the di / ase shock, or heart fail re. I Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular Accident /Medical Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to jor as a consequence of a Examiner requires that the death certificate be executed Atrial Fibrillation burial-tran Due to (or as a consequence of) Box 68760, physician a the burial Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f Division or Vital Records, P.O. 9□Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 21 No cate has l page 2 s 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 2 No 1 Inpatient 4√ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Certification: or Attending 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M:D D30132 October 15, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rita Ghosh MD 14812 Physicians Ln. Rockville, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State **T30** 1 7 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Patricia Ann Boccabella October 14, Day 2007 5:45 а м /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2 □ F 220-48-0528 Director 59 Dec. 5, 1947 Washington, DC Usual Residence of Decedent with the Maryland show 10a. State 10b. County 10c. City. Town or Location r 28a-f show notified at 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Examiner must be 18011 Queen Elizabeth Drive USA filed within 72 hours after death Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 Married 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2⊠ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 is 1 and 2 should be filed wof Health and Mental Hygier item 27 is marked other the other traumatic event, the Health Food Store Manager Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond G. Boccabella Helen I. Skelton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna M. Boccabella/Sister : If item 27 i 18011 Queen Elizabeth Drive, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 18. Pages Then 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2007 Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part1. Inter the disease, or complications that caused this death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Breast Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Jacase or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the ası IF FEMALE: for use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Day Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Junknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 SOther (Specify) 1 ☐ Yes ŽŽ No 2 ER/Outpatient 3 DOA Certification: To Hospice funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signarire and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D64615 October 16, 2007 and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wroblewski, MD 6001 Muncaster Mill Road, Rockville, MD 20855

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

OCT

Year)

7 2007

1

32. gistrar's Signature

			For State	State of Ma	ryland / [				ental Hyo	giene		
			1. Decedent's Name (First, Middle, Las	st)		Certificate	or Deali		2. Date of Dea	Reg. No.	2007	3 1, 98
ď	Physic /Medi		Russell C Burr	,					Month	Day	Year 2007	7:50 P
316	Exami		4a. Facility Name (If not institution, give	e street and number)		4b. City, 1	own, or Location	of Death	Octobe:		County of Death	
	in Branch		Frederick Memori				ederick				Frederi	ck
	Funeral Director		5. Social Security Number 6. S. 577-42-2926		(In yrs. last bir. <b>7</b> 3		Days Hours	Min.	8. Date of Birtl (Month, Day Feb • 2	h (, Year)	Cou	place (State or Foreigntry) ash. DC
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Maryli a-f sho iffed at	ctor	MD Frede	rick			etown					1 □Yes 2 🛣 No
	th with the 23a or 28 ust be not	al Director	3302 N • Hill	Ct.		10f. Zip (	21769			10g. Citiz	en of What Cou	ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? ↑X Yes 2 No If Yes, Give Year or Dates:	ver in U.S. 1952- 1956	13. Was Decede If Yes, speci			ify Yes or No- lican, etc.)		4. Race - Americ Black, White, Specify: Wh	etc.
21215-0036	within 72 ho iene. : than "natur the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+	<u> </u>	Decedent's Usual (Give kind of work life. DO NOT use ice-Pre	done during mo retired)		g	Me	d of Business/In tals ufactu	,
/land	uld be filed Mentai Hyg Irked other Itic event, i	To Be C	17. Father's Name (First, Middle, Last) Charles R. B						(First, Middle,	Maiden S		
, Mary	and 2 sho salth and 1 1 27 is ma er trauma	0 9	19a. Informant's Name/Relationship (7 Sandra Burr (W	ife)	19b.	Mailing Address (	Street and Number	ber or Rural	Route Numbe iddlet	r, City or OWN	Town, State, Zip	1769
Baltimore, Maryland	Pages 1 and the nent of He nent of He nent of He nent of He nent neutron or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	20b. Place of cemeter Refor	Disposition (Name y, crematory or oth med Cem	etery	10/19	0/07		ation - City or To	*
Balt	permit. Departr Importa any Inji		Storeture of un rel device Licen	horse		Donald P. O.	Admess of Thi Box 18	ompso , Mic	n Fun ldleto	era.	1 Home MD 21	769
T			23a Rart1. Enter the disease, or comp shock or fleart failure. List only	olications that gaused to one cause of each line	he death. Do n							Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Corcin	oid S	yndrox						Onset and Death
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence o	rf):						
	ecuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
68760,	ificate be executed g physician and as the burial-transit	edical Ex	resulting in death, East	Due to (or as a	consequence o							
P.O. Box 6	attending for use	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 □Live birth 2 4 □ Pregnant at ti 9 □ Unknown	☐ Fetal death	3 ☐ Ectopic pre 5 ☐ Other (spe				23	3d. Date of delive Month	ery Day Year
Vital Records, P.	N requires that the d been signed by the should be detached	by	Part II. Other significant conditions co	ontributing to death but	not resulting in	the underlying cau	use given in Part	I.				he cause of death?
<u>0</u>	aw req s beer 2 shou	Completed							24a. Was a	ın	24b. Were auto	psy findings available
ž	The lav	mo		· · · · · · · · · · · · · · · · · · ·					autops perfor 1□ Yes	med?	prior to co death?	mpletion of cause of
/Ita	siclan: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	,			26. Plac	e of Death (	Check only on		1 🗆 163	22140
	Physi this c	P	1 ☐ Yes 2 No	Hospital: 1 Inpatient							Other (Specif	(y)
Division or	ding I. After funel	ation:	27. Manner of Death Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. T	jury M	c. Injury at Work? 1 ☐ Yes 2 ☐	i	d. Describe h	ow injury	occurred	
2	- 0	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	(Specify)			l, c	City or Towi	n, State)		al Route Number,
	To the Hospital of within 24 hours aff To the Funeral D completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	vslclan: To the best of Iner: On the basis of e and manner state	xamination and	death occurred a for investigation, i	t the time, date a n my opinion, de	and place, ar	d due to the c	ause(s) a late and p	nd manner as s place, and due to	tated. the cause(s)
	To the comp	M	29b. Signature and title of certifier	4			License number				signed (Month,	
ì			Misty lee	Jul Willey	us h	D ON	0064	741		10/1	5/07	

State Registrar

DHMH 17 Rev 1/2001

Frederick Memorial Hospital, Frederick, MD

30. Name and address of death (Item 23a) (Type, Print)

Misty Leigh Williams

31. Date filed (Montl. Day Year) 2007

the death certificate be executed Box 68760. physician s the burial for use as Division or Vital Records, P.O. ed by the detached has page 2 the Hospital or Attending Physician: this completely filled in by the funeral after death. To the Hospital within 24 hours a To the Funeral C

**Funeral** 

Director

28a-f show

with 1

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

ral", or items 23a or 28a-f sh Examiner must be notified

items 23a

'natural', or

Health and Mental Hygiene. tem 27 is marked other than "

permit. Pages 1 and 2 statement of Health an Important: if item 27 is any injury or other trauonce.

**Physician** 

**Examiner** 

/Medical

State Registrar

Medical

29b. Signature and title of certifier

6 ☐ Could not be

determined

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

43643

Frederick St.

1 ☐ Yes 2 ☐ No

10-16-07

21783

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAG

A. 1480-

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

31. Date filed (Month, Day, Year) **QLT**, **17**, 2007

32. Begistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last 200<sup>Year</sup> Month **Physician** October 4:30 AM Genevieve Brudzinski /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Brighton Gardens of Columbia Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 21, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 🛣 F Poland 86 065-14-8174 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Columbia ( ) MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 2 and 1 may Injury or other traumatic event, the Medical Examiner must be no once. 21045 USA 7110 Minstrel Way Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contractor 12 Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Zakrzewska Joseph Lipski 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Grassy Road Orr's Island. ME 04066 Tom Brudzinski/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory | 10/16/07 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Service Lic Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 Approximate Interval Between Onset and Death 23a. Part1. Enter the diease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 5 years a. Alzheimer's Dementia disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-tra Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Type II Diabetes Mellitus 1 🗌 Yes 2√ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify 15 ing 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending 1 X Natural 1 ☐ Yes 2 No

**Physician** /Medical Examiner and

the Maryland

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed attending physician for use as the buria signed by been has e 2 this certificate uneral After

Division or Vital Records, P.O. Box 68760,

s after deau. ral Director: Aft filled in by within 24 hours a

2 Accident 3 ☐ Suicide 4 Homicide

29a, Certifier

(Check only one)

29b. Signature and title of certifier

E 6,10 State

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number D56531

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) October 15, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harry Li, M.D. 8600 Snowden River Pkwy. #301 Columbia, MD 21045

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month Co

investigation

6 Could not be determined





Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:45 P M 19. October 2007 Herbert Alan Butler /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Denton 8459 New Bridge Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1₹QM 2∏ F Director 212-40-9007 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show way Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Directo Denton Maryland Caroline 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States of America 21629 8459 New Bridge Road 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 3altimore, Maryland 21215-0036 Specify þ Caucasian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 is marked other than "7 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer HS Grad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hulda Bertha Andrew Wilbert Perry Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sinent of Health an ant: If Item 27 Is 1 9431 Turkey Creek Road, Easton, Maryland 21601 Michael Butler Son20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/23/2007 Denton, Maryland 4 □ Donation 5 □ Other (Specify) Denton Cemetery 22. Name and Address of Facility Moore Funeral Home, P.A. Denton, Maryland. 21629 21. Signature of Funeral Service Lice ser 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pourly differentiated Carcinoma Immediate Cause (Final disease or condition resulting in death) 5 Moutus Metastatic Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending p for use as use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. cate has been signed by the page 2 should be detached 9 I Inknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier DU053815 2007 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Korah Pulimood, M.D.,

31. Date filed (Month, Day, Year)

32. Reg

**ORIGINAL** 

912 Market Street, Denton, Maryland 21629

AS 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 0 7 For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Rebecca Jane Bowen **OCTOBER** 14, 2007 02:05P /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🖸 F 51 219-68-8806 Director Aug 27 1956 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medi al Examiner must be notified at 1 ☐ Yes 2X No Director Westminster Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 723 Hook Road 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZŽ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monce. Awakenings Center Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irene Lee Depew ပ Leonard Daniel Bowen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1525 Clearview Road Union Bridge, MD Jayson Bowen/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/19/2007 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadow Branch Cemetery Westminster, MD 21. Signature of Juneral Service Licensee Pritts Furier all Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CHRONIC LYMPHOCYTIC LEUKEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 ☐ Ectopic pregnancy Month Dav 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FULMINANT HEPATIC FAILURE 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 28h Time of Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation vithin 24 hours after deam.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10-14 WIL D3Ø263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO. 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Accept OCT 16 2007 Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 34986

ry Bell		I- For	State	0		Trick yie		Certifi	cate of l	Death					Reg. N	0		To Tie	ne of Death
				e (First Middle	e.Last)									Date of D Month	Da	y Yea	ar		35 hrs
hysicia <sup>د ث</sup> Exami			effrey			Ro11								Octobe	г 22, 2	007	- ( Dag		
Exami	IGI	<u>J</u>	errey acility Name (i	f not institution	n gives	treet and nu	ımber)		4t	. City, Tov	vn, or Lo	ocation of	Death			4c. County Garrett	or Dea	uı	-
		4a. F	Sarrett Cou	ntv Memo	rial Ho	spital			- 1	Oaklan	d					_	Jae	V - (1 - 1 - a	/State or
					6. Sex	•	7. Age (	n yrs. last b	oirthday)	If Under		If Under	24Hrs.	8. Date of	f Birth(N	M/DD/YYY	Fore	eign W	e (State or ashington
Funeral			ocial Security N						Yrs.	Months	Days	Hours	Min.			, 1953		Country)	D.C.
Director		2	20-50-	9840	1 X I	1 2 F	53		115.					110 7 1					
			al Residence c				110	c. City. To	wn or Locatio	on									Inside City Limits
amy		10a.	State	10b. County					1.									1	Yes 2 X No
nd show	ō		Ш	Garr	ett			Oak.	land_	10f. Zip C	nde				10g.	Citizen of W	/hat C	ountry?	
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Director	10e	Street and Nu	umber					'						1 .,	المصداد	C+	a # 0 0	
he M	ă	2	439 St	ocks1a	ger	Road				2.	L550	1.07	:-0 / C=/	noify Ves r		nited	e - An	nerican i	ndian, Black,
vith t		11.	Marital Status			12. Was De		ver in U.S.	13. Wa	s Deceden es, specify	t of Hisp Cuban,	Mexican,	Puerto F	Rican, etc.	.)		ite, etc		
ath v item	Funeral	1 [	Never Mari	ned 2 N	/arried	1 Yes	Forces?	X No								Specify	. T.T	hite	
er de	Ē	3	Widowed	4X Di	vorced	If Yes, Give Y	ear			Yes 2				and done	- 11	6b. Kind of E			
rs aft ural' mine	<u> 후</u>	15	Decedent's	Education (Sp	ecify on	y highest gr	ade comp	leted) 1	6a. Deceden	it's Usual C lost of work	occupati ing life.	on (Give DO NOT	kınd ot w use retir	ed)	- [	ob. rand or s			,
hou "nat	je	-	Iementary/Se				(1-4 or 5-		Quinig in		•				l	0 -		+	Company
36 in 72 han dical	늴		12						Owner	r				· • •	-1-11 - <b>1</b> -4-	CONST iden Surnar		CIOI	Company
5-0036 iled within 7: Hygiene. d other than	Completed by	17	Father's Nam	e (First, Middl	e, Last)						- }					ilden Sumai	ne)		
fled Hy	Be		Howard									Cha	n Ch	nand1	er	City of T	our S	tate 7ir	Code)
2121 ould be fill Mental is marked ic event,	8	19	a. Informant's	Name/Relation	nship (T	ype, Print )			19b. Mailin	g Address	(Stree	et and Nur	nber or F	Rural Rout	e Numb	er, City or T	0 Mil, C	E E O	, ,
Shou shou and N		- 1	Howard						2788	Stoc	ksla	ager	Road	l, Oa	<u>klai</u>	nd, MD	2 1	V OF TOV	n. State
, Nand 2 salth cem 2			a Method of D	Disposition					ace of Dispo ematory or o	sition (Nan	ne of ce	metery,	1	Date	_ \	200. 2000		,	
more, MD 21215-0036 Rages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygewie Hours, If I titem 27 is marked outer than "matural", or items 23a or 28a-f she cother than "matural", or items 23a or 28a-f she contracting the Medical Examiner must be notified at once		1		2 X Cremati			I from Sta	te	harla	nd Cr	emai	torv	10	/26/0	7	Cumb	er1	and	, MD
Page Page Inent		4	Donation	5 Other	Specify			Cun	22.	Name and	Addres	s of Facili	ty	The same	0 20 0 1	Home	p	Δ	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiewit In item 27 is marked other than "natural", c important: If item 27 is marked other than "natural", c			. Signature of																
E. E. G. B. C.	_		Kath Ba. Part I. Ente	mu	V 00	lications in	at caused	the death.	Do not enter	the mode	of dying	, such as	cardiac (	or respirat	ory arre	st, shock, or	heart	1	Approximate Interva Between Onset and
ysicia		23	Ba. Part I. Ente failure. List	only one cau	se on e	ach line.	_		1:	10*	. dic	0000							Death
,Medica Examine		In	failure. List nmediate Caus	se (Final disea	ase a	Ather	oscler	otic c	aruiova	Scurai	حيين	casc							
LXumme		O	r condition res	uiting in deau			as a cons	squerice or	<i>)</i> ·										
	١,	s	equentially list any, leading to	conditions,	b	Due to (or	as a cons	equence of	);			-							
	3	⊏ເດ	ause. Enter U	nderlying Cau	ise c														
			Disease or inju- vents resulting	iry that initiate g in death) La	st .	Due to (or	as a cons	equence of	·):										
uted	ransı																		·
exec	1al - 1	Medical	X UNPEND	DED	L	A#535	PII,	27, perl	Æ,g873	<u>, 11/1, </u>	/07 ]	T				23d. Da	te of d	elivery	
60, ate be	ine bui	ĕ⊨	F FEMALE:		in the			me of preg	nancy	Fetal deat	h :	Ecto	pic preg	nancy		Mor		Da	y Year
387 rtific ling p	as th	23 23	3b. Was deced past 12 mo	ient pregnant inths?	in me		ive birth Pregnant a	t time of de		Other (Sp						1			
th ce	r use	<u>[2</u>	Yes 2	No 9	Unknow		Jnknown		5	Other (9)	,								f 14h2
Bc le des	ed fo	Physician/	Part II. Other s	ignificant co	ndition	contribut	ing to dea	th but not r	esulting in th	ne underlyii	ng caus	e given in	Part I.						ne cause of death?
D. hat the	letac	<u>a</u>					9							_ [ '	1 Ye				bly 4 🗸 Unknow
ires t	d be	힔	Chror	nic alco	101 6	buse								24	4a. Was		24b. W	ere aut	opsy findings availa Impletion of cause o
rds requ	houl	힐												-		ormed?	d	eath?	
e law	ge 2 s	Completed													<b>✓</b> Yes	2 No	1	✔ Yes	2 110
Re : ⊤h	ır, pa		25. Was case	referred to me	edical						26.PI			ck only or		1- :	6	Other	
ital iciam	recto	m	examiner?			Hospital: 1	inpa	tient 2 🗸	ER/Outpat	ient 3	DOA	Other		rsing Hom		Residence how injury			
Phys	ral d	라	1 ✓ Yes 27. Manner of	Death		28a.	Date of It	njury	28b. Time	of Injury		Injury at V		28d. I	Describe	e now injury	occum	ou	
D C ding	fune	6	1 X Natura		Pendin	g			1			Yes 2							- Davida Number (
Siol Vitten deatl	oy the	cati	2 Accide	ent	Investig	ation 286	. Place of	Injury - At	home, farm,	street, fact	ory, offi	ce buildin	g, etc.	28f. L	ocation or Town,	(Street and State)	Numb	er or Ru	ral Route Number, (
after /	d in b	튀	3 Suicio		Could r determ	not be	necify)												
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 butus after death.	fille	Certification:	4 Homic	cide				my knowle	edge, death o	occurred at	the time	e, date ar	d place,	and due t	o the ca	use(s) and r	nanne	r as stat	ed.
e Ho:	letely		29a. Certifier (Check only one)	1 Certify 2 Medica	ing Phy il Exam	ner:On the	basis of e	xamınation	and/or inves	stigation, in	my opi	nion, dea	th occurr	ed at the	time, da				
Vithir E	duoc	Medical				and ma	nner state	ed			29c. Lie	cense nur	nber			290. Da	te org.	.04 (1110	,
	J	Σ	29b. Signatur	e and title of	A	,	1 10	1			0	.C.M.E				Octob	er 2	3, 200	7
			1/2	una /	Dia	sell	11/11	4		l									
			30. Name an	d address of p	erson v	ho complete	ed cause	of death (Ite	em 23a)	11 Penn	Stree	et. Baltii	nore. I	MD 212	01				
		2	Melissa	a Brassell,	MD	Assista	-	cal Exan		-									
	s	tate	31. Date filed	(Month Day	Year)	2007	32. Regi	strar's Sign	ature	Spech	1.								
	anis		I		E 4	1.00	19900000	Section Control											

Registrar

State of Maryland / Department of Health and Mental Hygien ? 34987 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 5:15 PM Brent 12 2007 10 Harve /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Wicomico at the Lake Under 1 Year If Under 24 H/s.
onths Days Hours Min. 8. Date of Birth (Month, Day, Year) 03-31-1930 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**⋈** M 2□ F Kentucky 77 403-34-4497 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location rthan "natural", or items 23a or 28a-f ehow the Medical Exauteer must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Princess Anne Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21853 11760 Robyn Lane death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or ite any injury or other traumatic event, the Medicial Exam can 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Korean Specify: Specify White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Uniform Company Branch Manager none 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Georgia Lee Scott Harvey Brent ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11760 Robyn Lane, Princess Anne, MD 21853 Grace Jackson Brent/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Scremation 3 Removal from State 10/15/2007 Salisbury, Maryland Salisbury Crematory 5 Other (Specify) 4 Donation 21. Signature of Funeral Septice Licensee Hinman Funeral Home 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each tine.

Immediate Cause (Final disease or condition) Princess Anne, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ye -nd /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 🖪 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No has page 2 autopsy performed? certificate 2. No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 COther (Specify) 1165 Pcce 1 Yes 2 No 3 DOA ို 2 ER/Outpatient this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 4 hours after death Funeral Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and titte of certifie D 29505

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month

GREGORIO M. BELLOSO, M.D.; 5502 CHINABERRY DR., SALISBERY, MD 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 26, October 2007 9:30 A Capper Elizabeth /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examine Williamsport Washington Homewood Retirement Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days March 2, 1923 Maryland Director 579-20-1935 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County must be notified at 1 □Yes 2 □ No Director Maryland | Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21740 17514 Lexington Ave Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🌠 No Baltimore, Maryland 21215-0036 Specify 2 3 ☐ Widowed 4 Divorced White Completed I 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther Erb Norman Miles ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a

If Item 27 is
or other train 17514 Lexington Ave Hagerstown Maryland 21740

be of Disposition (Name of Date 20c. Location - City or Town, State Brenda Burket / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If It any Injury or o once, 1 Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) 10/30/2007 Hagerstown Maryland Haven Cemetery 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Cervice License 1601 Pennsylvania Ave Hagerstown Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, S Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death | Check only one Be Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this . Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 28c. injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical mine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) соmpletely and manner stated within 2. To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of Registrar's Signature State 3 2007 Registrar

			1 - For State Registrar					tificate of		and Mental H	Reg. No.	-007	34989
	Physicia /Medic		1. Decedent's Name (First, Mic Dorothy E. Ch							Month	Day		2:05AM
7	Examin Funeral Director	er	4a. Facility Name (If not instituted of the control		PRSICL 7. Age	(In yrs. la:		If Under 1 Year Months Days	Je/1	AMO	ligh	Count	Reference (State or Foreign try)  Sylvania
			Usual Residence of Decedent  10a. State 10b. Cour	nty		10c. City,	Town or Lo	cation					0d. Inside City Limits
	e-feh	ctor	Maryland Ha	rford		Havi	re de	Grace			,		1 ☑ Yes 2 ☐ No
	death with the Maryland ms 23a or 28e-f ehow	Director	10e. Street and Number 839 Ontario S	+++++				10f. Zip Code				zen of What Coun	try?
\		by Funeral	11. Marital Status  1 Never Married 2 N  3 Widowed 4 MDiovord	12. W A larried 1	Vas Decedent firmed Forces?  ☐ Yes 2 M N Yes, Give Year or Dates:			21078 Was Decedent of I 1 Yes, specify Cub		gin? (Specify Yes or I , Puerto Rican, etc.)		14. Race - America Black, White, 6	
Maryland 21215-0036	be filed within 72 hours after ital Hygiane. d other then "naturel", or ite event, the Medical Examine	Completed	15. Dece (Specify only hig Elementary/Secondary (0-1:	<del></del>	n npleted) college (1-4or 5	+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most	of working		nd of Business/Ind	·
) pu	be filed tal Hyg d other event,	BeC	17. Father's Name (First, Midd	lle, Last)					18. Mothe	r's Name (First, Midd			
ylar	2 should be filed volume and Mental Hygia le marked other traumatic event, the	5	George Huguen							r (Aberg)		Town Chair Tin	Codel
Mary	s 1 and 2 should f Health and Men ftem 27 le marke other traumatic		19a. Informant's Name/Relation  George Huguen							Spring fie			
DOKOTHY Baltimore,	Department of permit. Page My Department of important: If any injury or	er	20a. Method of Disposition  1 □ Burial 2 □ □ Crematic  4 □ Donation 5 □ Other  21. Signature of Funeral Serv  23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying	(Specify)	elln	R.A.	Do not ent	23 S. Wa	ess of Facility	ton St. Ha	Wes.	Smith Fu	r, PA neral Home
الالالالالالالالالالالالالالالالالالال	Attending Physician: The law requires that the death certificate be executed rideath. sctor: Atter this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	ysiclan/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	1 4	Due to (or as  fyes, outcome □Live birth □Pregnant at □Unknown	of pregnan	cy death 3[	Ectopic pregnand	су		-	23d. Date of delive Month	ery Day Year
Division of Vital Records, P.	: The law requires that the de cate has been signed by the page 2 should be detached	Completed by Physician/M	Part II. Other significant cond	ral lial	Vasc	ut not resul	ting in the u $AS+D$	nderlying cause g	iven in Part I.	1 [ 24a. W	Yes 24	No 3 Prob	ne cause of death?  bably 4 Unknown  psy findings available  mpletion of cause of  2 DAO
sion of Vite	attending Physicien: The death. ctor: After this certificate his y the funeral director, page	Certification: To Be	Z C / KOOKGONK	Hospin 28 adding astigation	1 ∐ Inpatie Ba. Date of Inju (Month, Da	ry y Year)	R/Outpatier 28b. Time o Injury	f 28c. Inju	ther: 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4		esidence 6	y occurred	
Divis	P S S S		4 Homicide det	ermined 28	building, et	c." (Specify) at my know	Nedga, deat		timia, date an	28f. Location City or	Fown, State,	and manner as s	tated
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of cer		and manner sta				nse number			te signed (Month,	
	Sta Registi		30. Name and address of part 31. Date filed (Month, Day, Y	son who comple	ated usa of d	511	23a) (Type,	Print) & L	458 AW	Fret gland	DC X	tober	25,200 en

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amendati tem 19a per pinf 2873 11-8-07 Wental Hygiene 11-16-07 yt ate of Death 1- Statemend item11 per att g873 Reg. No 2007 34990 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** October 12, 2007 Year Soon W. Chung 1129 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Laurel Regional Hospital Laurel Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign South Korea **Funeral** Months Days Hours Min. March22,1946 229-17-1888 61 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits than "natural", or items 23a or 28a-f shove he Medical Examiner must be notified at VA Fairfax Director Springfield 1 ☐ Yes 2 XNo 10e. Street and Number 7007 Catlett Street 10f. Zip Code 22151 10g. Citizen of What Country? United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Asian 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) - 4 Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M General Contractor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kae H. Chung Yong A. Kim မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Young L. Yoon -wife friend 3018 Greencastle Road Burtonsville, Maryland 20866 20b. Place of Disposition (Name of cometery, crematory or other place)

Gate of Heaven Cemetery 10/17/2007 Silver Spring, Maryland 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Myoc andia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a conse juence of the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1☐ Yes 2☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident npletely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

2007

Registrar's Signature

funeral director, After this hours after death uneral Director:

28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29b. Signa	ure and	title of c	rtifier
		1	1201

29c. License number <del>D</del>24398 29d. Date signed (Month, Day, Year) October 15, 2007

npleted cause o death (Item 23a) (Type, Print) 30. Name and address of person vho c

M.D., 15225 Shady Grove Road, #302, Rockville, MD 20850 Philip J. Schwartz, 31. Date filed (Month, Day,

State Registrar

Certification:

Year) 2007 CCT 7



within 2

		•	For State Registrar	State of	Maryland / D		tment of Heificate of L		d Mei		iene ()	07	34992				
			1. Decedent's Name (First, Middle	e, Last)					2.	Date of Deat Month	h Day	Yeer	3. Time of Death				
	Physici /Medio		Mary Elmira Cu	mmings					0	ctober		2007	7:55A M				
	Examin		4a. Facility Name (If not institution	n, give street and num	ber)		4b. City, Town, or	Location of D	eath		4c. Count	y of Death					
			Homewood at Cr				Frederi		H C-		Fre	deric	3. Time of Death 7:55A M  n ck  place (State or Foreign unity)  10d. Inside City Limits 1 Yes 2 No  unity?  rican Indian, a, etc.  Thite  Industry				
	Funeral Director		5. Social Security Number 214–48–4187	6. Sex 7 1 ☐ M 2 🛣 F	. Age (In yrs. last birth		If Under 1 Year Months Days	Hours N	/lin.	Date of Birth (Month, Day, uly 14		Coul	ntry)				
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Loca	ation					1	10d. Inside City Limits				
	Marylan f ehow	ğ	VA Loude	oun	Love	ttsv	ville						1 ☐ Yes 2 🙀 No				
	r 28a-f	rec	10e. Street and Number				10f. Zip Code			1	0g. Citizen of	What Cour	ntry?				
	death with the Maryland me 23s or 28s-f ehow fraust be notified at	a D	38604 Morrison	ville Road			20180	)			USA	A					
Maryland 21215-0036	after or its	by Funeral Director	11. Marital Status  1 Never Married 2 Marr 3 XWidowed 4 Divorced	Armed Ford  1 ☐ Yes 2  If Yes Give	! X No	lf \	as Decedent of Hi Yes, specify Cubar	spanic Origin' n, Mexican, Pi Specity:	? (Specif uerto Ric	y Yas or No- an, etc.)		ack, White,	etc.				
Ö	naturel',	ted	15. Deceden	t's Education	16a. I	Decede	nt's Usual Occupa	tion	working		16b. Kind of 8	Business/In	dustry				
215	C	npie	Elementary/Secondary (0-12)	st grade completed)  College (1-		life. DO	nd of work done d O NOT use retired,		working								
2	s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Ma	Completed	12				Housewit					emaker	r				
nd	tal High doth	Be	17. Father's Name (First, Middle,							irst, Middle, f		me)					
Zla	2 should be and Mental is marked o raumatic eve	၉	Daniel David O							leria (			2.7.				
Mar	12 sh h and 7 is m iraum		19a. Informant's Name/Relations E. Todd Cummin			-	Morrico										
	1 and Health em 27 ther tr	-1	20a. Method of Disposition	gs, 5011	20b. Place of			IVILLE	Date								
Baltimore,	nt of I		1 ☑ Burial 2 ☐ Cremation		tate cemetery	r, crema	atory or other place										
Itin	rtant njury		4 □ Donation 5 □ Other (S	Contraction of the Contraction o	Old Br		ren Ceme Name and Addres		10/1	9/0/ _	Browns	AITTE	, MD				
Ba	permit. Pages 1 Department of H Important: If ite any injury or ot		Barbara A.  23a. Part1. Enter the disease, or	Williams,		Jo 10	ohn T. Wi JO Peters	illiams sville	Road	d, Brun	swick.	, MD	The state of the s				
	Physician and // Medical Examiner the pnian-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	ras a consequence or a consequence or a c	f).	He cont	far y D	10 r	~. • \( \sum_{\text{\tint{\text{\tin}\text{\tex{\tex			Onset and Death  10 years				
P.O. Box 6	ne death certific the attending p hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live bir	ome of pregnancy th 2 Fetal death nt at time of death wn		ectopic pregnancy Other (specify)					ate of deliv	ery Day Year				
Division of Vital Records, P.	juires that the signed by ald be detacted	þ	Part II. Other significant condition	ons contributing to dea	ath but not resulting in	the und	derlying cause give	n in Part I.		23e. Did tol	~	ntribute to t	he cause of death?				
S	≥ D 55	Completed		U						24a. Wasa	n 24b	. Were auto	opsy findings available ompletion of cause of				
æ	The lay ate hes page 2	E O							_	autops	nett?	death?					
tal		0	25. Was case referred to medica	ı		-		26. Place of	Death //	1 □ Yes : Check only on	22 Np	1 🗌 Yes	2   NO				
Ξ	S .s .च	ToB	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ In	patient 2 ER/Out	patient	3□ DOA Othe	71		5 ☐ Reside		ther (Specia	fy)				
0	Ds 00 00	ü	27. Manner of Death	28a. Date of	Injury 28b. Ti	ime of	28c. Injury Work			d. Describe ho							
ō	Attending ir death. ector: After by the fune	atic	2 Accident investi	gation		,		res 2 □ No									
Ξ	r Att	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined 28e. Place of buildin	of Injury - At home, far g, etc. (Specify)	m, stree	et, factory, office		28	f. Location (SI City or Town	reet and Nun n, State)	ber or Aur	al Route Number,				
	urs af	S															
	To the Hospitei or Attendin within 24 hours after death. To the Funerei Director: Att completely filled in by the fun	ledicai		ng Physician: To the I Examiner: On the base	sis of examination and												
	ithin in the or	Med	29b. Signature and title of certifie	and mann	or stated.		29c. License	number		2	9d. Date sign	ed (Month	Day, Year)				
	4 ≥ ₹ ۶		) n.	h. P.			Dr	968	9			1/16	)				
4	0		30. Name and address of person	who completed cause	of death (Item 22a)	Type P		166	(		•	//6	/ 0 /				
-			Austin Pearre,	•	300 West 9			Freder	ick,	MD							
	Sta Registi	_	31. Date filed (Month, Day, Year, OCT 1		gistrar's Signature												

TODS 7:550M

DOD: 10/16/07

Fracus to physician as Cummings, Mary

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 15, 2007 2:55 CHEW FLORENCE Α 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
July 26, 1 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Days Months 1 ☐ M 2 🖫 F 194-14-6727 83 1924 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □Yes X□No Maryland Frederick Union Bridge 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 13103 New Windsor Road 21791 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry K. Ostien Cecelia Arnold 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra A. Tetlow - Daughter 8536 Apples Church Road, Thurmont, Maryland 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 10/19/07 Frederick, Maryland 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 21. Sign Iture of Funeral Service Licens 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DAYS Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): neum onia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of): Kr. in RVC Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 20 INO 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner that the death certificate be executed and burial-tran P.O. Box 68760, physician the

attending pl

funeral

Division or Vital Records,

the Hospital or Attending

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

23a or

o

"natural",

Medical Examiner must be

event, the

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 is marked other I any Injury or other traumatic event, <u>tit</u>

Director

Funeral

þ

Completed

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Medical Examiner

To the Hosping.
within 24 hours after death.
To the Funeral Director: After a consistent of the funeral by the funeral part of

25. Was case referred to medical examiner? 20 No 1 ☐ Yes 27. Manne of Death 1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

2	ŧ
<u>.a</u>	
.9	1
S	ı
ځ	١
Ф.	
>	
=	
8	
퓽	
ᇹ	
E	
ō	
O	ĺ.
Be	
.0	
Η.	t
c	1
.0	1
at	1

Medical Certific

State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

BOLARUM, MD 196 TJORIVE, PLOSHIL, MO21702 30. Name and address of purson who completed cause of death (Item 23a) (Type, Print)

Hospital:

5 Pending investigation

6 Could not be determined

OCT 1 8 2007

1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

pgistrar's Signature

2 ER/Outpatient 3 DOA

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00062223

1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 10/16/2007 LINDA A. CORRADO 10:00 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Wicomico 7352 Richardson Street Willards If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 1 □ M 2 🔀 F Days 59 Yrs. 214-52-2493 5/23/1948 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director Wicomico Willards 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21874 USA 7352 Richardson Street Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. Specify: þ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Retail 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jeanne Miller William Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7352 Richardson Street, Willards, MD 21874 Ronald Corrado (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/19/2007 Pocomoke City, MD First Baptist Cemetery 21. Signature of Fundal Service Licensee 22 Name and Address of Facility Holloway Funeral Home, Professional Association 103 Linden Ave., Pocomoke City, MD 21851 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastasis Due to (or as a consequence of): lung Cancer Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: NA 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>^</u> 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 1 ☐ Yes 25. Was case referred to medical examiner? under Hospice Care 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation NA 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans Division or Vital Records, P.O. Box 68760 as inding pure atten for u has certificate ha After within 24 hours after death

To the Funeral Director:
completely filled in by the

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier Ulu

(Check only

29c. License number D0066169 29d. Date signed (Month, Day, Year) 10/17/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- Peninsula Regional Primary Care, 10445 Ocean City Blvd, unit#1 Angela L. Gibbs, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Medical

OCT 1 8 2007

BA 6

7984		Please Type or Print in Black In						
ia Lynn Dow		State of Maryland / Depa			ntal Hygi	iene		007 010
	R	Renietrar	tificate of De	eatn 	2	Reg. Date of Death	No.	3. Time of Death
Physician ical Examine	-	1. Decedent's Name (First, Middle,Last)  Toykia Lynn Dow					ay Year 2007	
		4a. Facility Name (if not institution, give street and number)	4b. Ci	ty, Town, or Location			4c. County of	f Death
		Prince George's Hospital Center	Ch	neverly			Prince G	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I						Birthplace (State or Foreign
Director		$067-64-5978 \mid_{1_{M}} 2X_{F} \mid 37$	7 Yrs.	onths Days Hour	rs Min.	1/31/1	970	Country) N . Y .
	_	Usual Residence of Decedent						10d. Inside City Limits
w any			Town or Location					1 X Yes 2 No
Maryland 28a-f show any d at ouce.	<u>ā</u>			7: 0. 1:		1400	Citizen of Wh	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 118 2nd Street	101	. Zip Code 12210		109	USA	
th the 23a or	- 1		C 13 Wes Do	cedent of Hispanic Or	rigin? / Speci	ify Ves or No-		- American Indian, Black,
tems st be	<b>=</b> 1	11. Marital Status 1 XNever Married 2 Married Armed Forces?	If Yes, s	pecify Cuban, Mexica	an, Puerto Ric	can, etc.)	White	e, etc.
er dea		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes	2 X No specif	īy:		Specify:	Black
urs aft	화	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's U	sual Occupation (Give	e kind of wor		6b. Kind of Bu	siness/Industry
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		f working life. DO NO	I use retired	)	Com	~~
ithin and the fedical	E I	12	Longsn	oreman			Car	
J-UU30 lfed within 7. Hygiene. J other than the Medical	8	17. Father's Name (First, Middle, Last)			er's Name (F ris De	irst, Middle, Ma	iden Surname)	)
ental ]	8	David Harrison	Later Admilian Admi	dress (Street and No			or City or Tow	n State Zin Code)
should and Mer 7 is man	우	19a. Informant's Name/Relationship (Type, Print) Willie Vice / Uncle	14 Cla	iress (Street and No.	ie Al	bany, N	ew Yo	rk 12202
nd 2 salth a sen 27 raum	-		Place of Disposition					- City or Town, State
of He If it			crematory or other p		10/	20/07	Albaı	ný, N.Y.
EIM Pag tment tant:	ļ	4 Donation 5 Other Specify.  21. Signature of Funeral Service Licensee			ility			
Baltimore, permit. Pages I as Department of He Important: If ite		21. Signature/of Funeral Service Ucensee	PHIL	IP D. RIN	ÄLDI	FUNER	AL SEI	RVICE, P.A.
	4	23a. Part I. Enter the disease, or complications that caused the death	h. Do not enter the m	ode of dying, such as	s cardiac or r	espiratory arres	t, shock, or he	oring Md2091( art Approximate Interval
Physician /Medical		failure. List only one cause on each line.						
			act					Between Onset and Death
caminer		Immediate Cause (Final disease or condition resulting in death)  a. Gunshot Wound to Ch  Due to (or as a consequence						
caminer		or condition resulting in death)  Due to (or as a consequence			·			
	ner	or condition resulting in death)  Due to (or as a consequence b.  Sequentially list conditions, if any, leading to immediate Due to (or as a consequence Due to (or as a c	of):					
	aminer	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	of):					
	Examiner	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  Clisease or injury that initiated	of):					
		or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	of):					
		or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  Due to (or as a consequence of Due to (or as a c	of): of): of):				23d. Date of	Death
	an/Medical	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  Due to (or as a consequence d.  AMENDED  23c. If yes, outcome of pregnant in the past 12 months?	of): of): of): egnancy 2 Fetal of		opic pregnanc			Death
	sician/Medical	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  Due to (or as a consequence of Due to (or as a c	of): of): of): egnancy 2 Fetal of	leath 3 Ecto			23d. Date of	Death
	an/Medical	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  Due to (or as a consequence d.  AMENDED  23c. If yes, outcome of present 1 Live birth 4 Pregnant at time of or	of):  of):  of):  gnancy  2 Fetal of death 5 Other	(Specify)	opic pregnanc	cy	23d. Date of Month	Death
	by Physician/Medical	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unknown  Due to (or as a consequence d. Due to (or as a consequence d. Purchase)  Live birth  Pregnant at time of or g Unknown	of):  of):  of):  gnancy  2 Fetal of death 5 Other	(Specify)	opic pregnanc	cy 23e. Did tot	23d. Date of Month	f delivery Day Year
	by Physician/Medical	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unknown  Due to (or as a consequence d. Due to (or as a consequence d. Purchase)  Live birth  Pregnant at time of or g Unknown	of):  of):  of):  gnancy  2 Fetal of death 5 Other	(Specify)	opic pregnanc	23e. Did tot 1 Yes 24a. Was a	23d. Date of Month	f delivery Day Year  ribute to the cause of death? Probably 4 Unknown Were autopsy findings available
	by Physician/Medical	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unknown  Due to (or as a consequence d. Due to (or as a consequence d. Purchase)  Live birth  Pregnant at time of or g Unknown	of):  of):  of):  gnancy  2 Fetal of death 5 Other	(Specify)	opic pregnanc	23e. Did tot 1 Yes 24a. Was a autops perform	23d. Date of Month  Nacco use control  2 V No 3  y  ned?	f delivery Day Year  ribute to the cause of death? Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?
Records, P.O. Box 68 / 60,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Completed by Physician/Medical	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unknown  Part II. Other significant conditions  Due to (or as a consequence d. Due to (or as a consequence d. Pull to (or as a consequence d. Due to (or as a consequence d. Due to (or as a consequence d. Due to (or as a consequence conditions)  Due to (or as a consequence conditions)  Due to (or as a consequence conditions)  Due to (or as a consequence condition of consequence consequence)  Due to (or as a consequence condition of consequence conditions)  Due to (or as a consequence condition of conditions)  Due to (or as a consequence condition of conditions)  Due to (or as a consequence condition of conditions)	of):  of):  of):  gnancy  2 Fetal of death 5 Other	(Specify)	opic pregnand	23e. Did tot 1 Yes 24a. Was a autops perfor 1 Yes 2	23d. Date of Month  Nacco use control  2 V No 3  y  ned?	f delivery Day Year  ribute to the cause of death? Probably 4 Unknown  Were autopsy findings available prior to completion of cause of
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Be Completed by Physician/Medical	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  Contributing to death but not examiner?  Due to (or as a consequence d.  Due to (or as a consequence d.  Due to (or as a consequence contribution of the past 2 contribution of the past 2 contribution of the past 12 months?  Due to (or as a consequence contribution of the past 12 months) or contribution of the past 12 months?  AMENDED  23c. If yes, outcome of preserved to preserved to medical examiner?	of): of): of): egnancy 2 Fetal of death 5 Other resulting in the under	(Specify)  orlying cause given in  26.Place of Dec	opic pregnand Part I.	23e. Did tot 1 Yes 24a. Was a autops perfor 1 Yes 2	23d. Date of Month  Nacco use control  2 V No 3  y  ned?	f delivery Day Year  ribute to the cause of death? Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  25c. Was case referred to medical examiner?  1 Ves 2 No 27. Manner of Death  Due to (or as a consequence of Du	of):  of):  of):  gnancy  2 Fetal of death 5 Other	(Specify)  orlying cause given in  26.Place of Dea	ppic pregnand Part I.  ath (Check or Nursing lork?	23e. Did tot 1 Yes 24a. Was a autops perfon 1 Yes 2  1ly one)  Home 5 1	23d. Date of Month  acco use control  2  No 3  y  ned?  Residence 6  ow injury occur	ribute to the cause of death?  Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  Yes 2 No  Other:
Records, P.O. Box 68 / 60,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 Ves 2 No 27. Manner of Death  1 Natural 5 Pending  Due to (or as a consequence c.	of): of): of): egnancy 2 Fetal of death 5 Other resulting in the under	(Specify)  orlying cause given in  26.Place of Dea	Part I.  ath (Check or Nursing Vork?	23e. Did tot  1 Yes  24a. Was a autops perfor  1 Yes 2  1ly one)  Home 5	23d. Date of Month  acco use control  2  No 3  y  ned?  Residence 6  ow injury occur	ribute to the cause of death?  Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  Yes 2 No  Other:
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5 Pending 28e. Place of Injury - Atcident  Due to (or as a consequence of Due to (or	of):  of):  of):  of):  gnancy 2 Fetal of 5 Other  resulting in the under  ER/Outpatient 3  28b. Time of Injure 2227 hrs	26.Place of Dea DOA Other Yes 2	Part I.  ath (Check or Nursing York?	23e. Did tot  1 Yes  24a. Was a autops perfor  1 Yes 2  hly one)  Home 5 1  28d. Describe h Subject shot	23d. Date of Month  2 No 3  n y ned? No Residence 6 ow injury occur	f delivery Day Year  ribute to the cause of death? Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  Yes 2 No  Other:  rred
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1  Yes 2 No 27. Manner of Death  1  Natural 5 Pending 2  Accident Investigation 3  Suicide 6 Could not be determined (Specific) L and Str.	of):  of):  of):  of):  gnancy  2  Fetal of the fetal of	26.Place of Dea DOA Other Yes 2	Part I.  ath (Check or Nursing York?	23e. Did tot  1 Yes  24a. Was a autops perfor  1 Yes 2  hly one)  Home 5 1  28d. Describe h Subject shot	23d. Date of Month  2 No 3  n y ned? No Residence 6 ow injury occur	f delivery Day Year  ribute to the cause of death? Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  Other:
Division of Vital Records, P.O. Box 68760, spin of Vital Records, P.O. Box 68760, spinal or Attending Physician: The law requires that the death certificate has been signed by the attending physician and meral Director. After this certificate has been signed by the attending physician and y filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 ✓ Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 ✓ Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined  29a. Certifier 1 Certifular Physician: To the best of my knowless	of):  of):  of):  of):  gnancy 2 Fetal of the second of th	26.Place of Dea Other 4 y 28c. Injury at W 1 Yes 2 actory, office building	Part I.  ath (Check or Nursing York?  No  1, etc.  2  1 place, and of	23e. Did tot  1 Yes  24a. Was a autops perfor  1 Yes 2  28d. Describe h Subject shot 28f. Location (S or Town, S' 445 Kent Villi	23d. Date of Month  2 No 3  No 24b.  Residence 6 ow injury occur  treet and Numl ate) age Place, H	Death  f delivery Day Year  ribute to the cause of death? Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  1 V Yes 2 No  Other: rred  ber or Rural Route Number, City yattsville, MD er as stated.
Division of Vital Records, P.O. Box 68760, spin of Vital Records, P.O. Box 68760, spinal or Attending Physician: The law requires that the death certificate has been signed by the attending physician and meral Director. After this certificate has been signed by the attending physician and y filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 ✓ Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 ✓ Yes 2 No  27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined  4 ✓ Homicide  Due to (or as a consequence of Due to (	of):  of):  of):  of):  gnancy 2 Fetal of the second of th	26.Place of Dea Other 4 y 28c. Injury at W 1 Yes 2 actory, office building	Part I.  ath (Check or Nursing York?  No  1, etc.  2  1 place, and of	23e. Did tot  1 Yes  24a. Was a autops perfor  1 Yes 2  28d. Describe h Subject shot 28f. Location (S or Town, S' 445 Kent Villi	23d. Date of Month  2 No 3 n y ned? No 24b. Residence 6 ow injury occur treet and Num ate) age Place, H e(s) and manne	ribute to the cause of death?  Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  Yes 2 No  Other:  rred  ber or Rural Route Number, City yattsville, MD  er as stated. due to the cause(s)
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 ✓ Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death  1 Natural 5 Pending Investigation  3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  29 Medical Examiner: On the basis of examination	of):  of):  of):  of):  gnancy 2 Fetal of the second of th	26.Place of Dea  DOA  Other  Yes 2  actory, office building  at the time, date and, in my opinion, death	Part I.  ath (Check or Nursing York?  No  J, etc.  2  d place, and con occurred at	23e. Did tot  1 Yes  24a. Was a autops perfor  1 Yes 2  28d. Describe h Subject shot 28f. Location (S or Town, S' 445 Kent Villi	23d. Date of Month  acco use control 2 No 3  n y 24b.  Residence 6 ow injury occur  treet and Numi ate) age Place, H 2(s) and manner and place, and	Death  f delivery Day Year  ribute to the cause of death? Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  Yes 2 No  Other:  rred  ber or Rural Route Number, City yattsville, MD  er as stated. due to the cause(s)
Division of Vital Records, P.O. Box 68/60, spin or Attending Physician: The law requires that the death certificate be executed hours after death.  Internal Director: After this certificate has been signed by the attending physician and yfilled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 Ves 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physician: To the basis of examination and manner stated.	of):  of):  of):  of):  gnancy 2 Fetal of the second of th	26.Place of Dea DOA Other 4 y 28c. Injury at W 1 Yes 2 actory, office building at the time, date and , in my opinion, death	Part I.  ath (Check or Nursing York?  No  J, etc.  2  d place, and con occurred at	23e. Did tot  1 Yes  24a. Was a autops perfor  1 Yes 2  28d. Describe h Subject shot 28f. Location (S or Town, S' 445 Kent Villi	23d. Date of Month  2 No 3 n y ned? No 24b. Residence 6 ow injury occur treet and Num ate) age Place, H e(s) and manne	Death  f delivery Day Year  ribute to the cause of death? Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  Yes 2 No  Other:  rred  ber or Rural Route Number, City yattsville, MD  er as stated. due to the cause(s)
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 Ves 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physician: To the basis of examination and manner stated.	of):  of):  of):  of):  of):  gnancy  2	26.Place of Dea  DOA  Other  y 28c. Injury at W  1 Yes 2  actory, office building  at the time, date and, in my opinion, death  O.C.M.E.	Part I.  Part I.  Part I.  Part I.  Part I.  Part I.  Part I.  Part I.  Part I.  Part I.  Part I.	23e. Did tot 1 Yes 24a. Was a autops perfort 1 Yes 2 7	23d. Date of Month  acco use control 2 No 3  n y 24b.  Residence 6 ow injury occur  treet and Numi ate) age Place, H 2(s) and manner and place, and	Death  f delivery Day Year  ribute to the cause of death? Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  Yes 2 No  Other:  rred  ber or Rural Route Number, City yattsville, MD  er as stated. due to the cause(s)
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 Vey 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Str (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	of):  of):  of):  of):  of):  gnancy  2	26.Place of Dea  DOA  Other  Yes 2  actory, office building  at the time, date and, in my opinion, death	Part I.  Part I.  Part I.  Part I.  Part I.  Part I.  Part I.  Part I.  Part I.  Part I.  Part I.	23e. Did tot 1 Yes 24a. Was a autops perfort 1 Yes 2 7	23d. Date of Month  acco use control 2 No 3  n y 24b.  Residence 6 ow injury occur  treet and Numi ate) age Place, H 2(s) and manner and place, and	Death  f delivery Day Year  ribute to the cause of death? Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  Yes 2 No  Other:  rred  ber or Rural Route Number, City yattsville, MD  er as stated. due to the cause(s)
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 ✓ Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 Ves 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident 1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not be determined (Specify) Local Str  29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.  30. Name and address of person who completed cause of death (Ite Carol Allan, MD Assistant Medical Examiner Sign.)  Due to (or as a consequence of Due to (or	of):  of):  of):  of):  of):  gnancy 2 Fetal of the second	26.Place of Dea  DOA  Other  y 28c. Injury at W  1 Yes 2  actory, office building  at the time, date and, in my opinion, death  O.C.M.E.	Part I.  Part I.  Part I.  Part I.  Part I.  Part I.  Part I.  Part I.  Part I.  Part I.  Part I.	23e. Did tot 1 Yes 24a. Was a autops perfort 1 Yes 2 7	23d. Date of Month  acco use control 2 No 3  n y 24b.  Residence 6 ow injury occur  treet and Numi ate) age Place, H 2(s) and manner and place, and	Death  f delivery Day Year  ribute to the cause of death? Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  Yes 2 No  Other:  rred  ber or Rural Route Number, City yattsville, MD  er as stated. due to the cause(s)

			For State of Maryl			of Health of Death		-			
		-	Registrar     Decedent's Name (First, Middle, Last)		erimeate	or Death		2. Date of De	Reg. No.	.00/	3. Time of Death
	Physicia /Medic		LOYD L. A.	DODSON	SR.			Month OCT -	13,	Year <b>2007</b>	11:40 A M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, T	Town, or Location	of Death			ounty of Dea	
			<b>5011 55th AVE</b> .  5. Social Security Number 6. Sex 7. Age (In	um loot hirtholo	(N) If Under	HYATTSV	ILLE r 24 Hrs.	O Date of Bi			GEORGES
	Funeral Director		1 <b>™</b> M 2□ F	yrs. last birthda Yrs.	Months	Days Hours	Min.	8. Date of Bir (Month, Da JAN. 30	ay, Year)	Co	thplace (State or Foreign ountry) VIRGINIA
P			Usual Residence of Decedent					JAM. J	J, 155	)	VIRGINIA
arylar	show	'n	10a. State 10b. County 10c	. City, Town or	Location						10d. Inside City Limits 1 X Yes 2 □ No
the M	28a-f iotifie	Director	MD. PRINCE GEORGES  10e. Street and Number		HYATT 10f. Zip (	CONTRACTOR			10a Citizo	n of What Co	-
with	3a or		5011 55th AVE.		101. 2101						ountry?
death	ems 2 r mus	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 1	3. Was Decede	20781 ent of Hispanic O ify Cuban, Mexica	rigin? (Spe	cify Yes or No		Race - Ame	
after after	or ite		1 ☐ Never Married 2 M Married 1 ☐ Yes 2 M No If Yes, Give		1 ☐ Yes 2			nican, etc.)		Black, Whit	
y hours	tural" al Exa	ed by	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education	16a Dec	cedent's Usual					of Business	HITE
<b>2</b> 7 nin 72	n "na Nedic	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Gi	ive kind of work . DO NOT use	k done during mo e retired)	st of worki	ng	100. Kind	of business	industry
U K I K I 3-0030 filed within 72 hours after death with the Maryland	/giene er tha ;, the l	Completed	5		TRUCK	DRIVER			7	RUCKII	NG
be file	ntal Hy ed oth event	Be	17. Father's Name (First, Middle, Last)			18. Moth		(First, Middle		,	
hould	h and Mental Hygiene. 7 is marked other than " traumatic event, the Mec	ပ္	LURTHER DODSON  19a. Informant's Name/Relationship (Type. Print)	19h Ma	ailing Address	(Street and Numb		ATILDA		ICHOL:	
Ma nd 2 s	alth an 27 is r trau	3	HELEN V. DODSON/WIFE	501	-	th AVE.					' '
es 1 a	of Heg	3	20a. Method of Disposition 20	Db. Place of Dis				ate		ition - City or	
Page	ant: If		1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other ( <i>Specify</i> )	СНАМВЕ			10-17	<b>7–2007</b>	R1	VERDAI	LE, MD.
permit.	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licepsee	100091	CHAMB	Address of Faci BERS FUNI CLEVELAN	ERAL	HOME &	CREMA ZERDAT	TORIU	M,P.A. 20737
r ·			23a. Part1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.							Lly IID	Approximate Interval Between
	ysician		Immediate Cause (Final disease or condition METASTATT	C GASTI	RIC ADE	NOCARCII	AMO				Onset and Death 3 MONTHS
	Medical caminer		resulting in death)  Due to (or as a con	sequence of):		-			•		
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a con	nsequence of):						···	
cuted	ansit	Examiner	Cause. (Disease or injury that initiated events								
e exe	ian ar urial-t	Ex	resulting in death) Last Due to (or as a con	sequence of):							
do / do, ficate be executed	been signed by the attending physician and should be detached for use as the burial-transit	edical	d								
certifi	nding use as	/Me	IF FEMALE: 23c. If yes, outcome pf programs and the state of the state	egnancy					23	d. Date of de	livon
death	e atte	Physician/M	in the past 12 months?		3 □Ectopic pre 5 □ Other <i>(spe</i>				20	Month	Day Year
at the	by th	Phys	9 ☐ Unknown								
ires th	signed I be d	þ	Part II. Other significant conditions contributing to death but not	t resulting in the	e underlying ca	use given in Part	1.				o the cause of death? robably 4 ▼Unknown
v requ	been	eted	14,000,1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	-							
he lay	e has	Completed						24a. Was auto perf		prior to death?	utopsy findings available completion of cause of
an: Tan	rtificat tor, pa	Be Co	25. Was case referred to medical			26. Plac	e of Death	1☐ Yes (Check only	2 No	1 □ Yes	3 2 □ No
hysic	his ce I direc	To B	examiner? 1 ☐ Yes 2 X No Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpat	tient 3 □ DO	Othor		ne 5 <b>X</b> Res		☐Other (Spe	ecify)
ling	After t	ion:	27. Manner of Death 1 Natural 5 Pending (Month, Day Yea	28b. Time Injury	у	3c. Injury at Work?		28d. Describe	how injury	occurred	
Attend	death ctor: y the 1	icati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - Acceptance 28e.	At home, farm,	M street, factory.	1 ☐ Yes 2 ☐		28f Location /	Street and	Number or P	ural Route Number,
ital or A	rs after ral Dire lled in b	Certification:	4 Homicide determined building, etc. (Sp	pecify)				City or To	wn, State)		
he Hosp	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier  (Check only one)  1X Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	knowledge, de mination and/or	eath occurred a r investigation,	at the time, date a in my opinion, de	and place, a	and due to the ed at the time	cause(s) a , date and p	nd manner a lace, and du	s stated. e to the cause(s)
To t	To t	Σ	29b. Signature and title of certifier	111	7 29c.	License number	-	_			th, Day, Year)
	16		90	ice		D09.	35		Oe	t/5	0.7
4			30. Name and address of person who completed cause of death and address of Death LILLY, M.D.			AVE., I	TYATT	SVILLE	MD.	20781	
	Sta		31. Date filed (Month, Day, Year) 32. Sigistrar's S	Signature		_		- + - 111111	,	_0/01	
	Registr	ar	ACT 1 7 2007 A Server	17. 6	Society 9						

DHMH 17 Rev 1/2001

Amended Item 26 per Physician 10/16/2007 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October <sup>™</sup>¥1 2007 **Physician** 1:00 a M Susan Carol De Ford /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carrol1 Westminster Carroll Hospice Dove House Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 □ M 2 🔀 F 54 215-60-2511 22 1953 MD Director May Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Carroll Westminster MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21157 2006 Reese Road Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Specify: 9 3 Widowed 4 Ovivorced Year or Dates Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hyglene, int: if Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Data Entry Clerk PHH permit, Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if Item 27 is marked other any injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irene Lillian Heckel Calvin Davis De Ford ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4201 N. Hunter Road Hampstead, MD Matthew De Ford/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/15/2007 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Finksburg, MD Evergreen Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) Printend Furneral Mome and Chapel, P.A. 21. Signature of Funeral Service Licenun 21157 412 Washington Road Westminster, MD Approximate Interval Betwee Onset and Dea 23a. Part f. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) physician Physician/Medical attending for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 2 Fetal death 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director. Be Other: 4 Nursing Home Hospital: cnoe 6 KlOther (Specify) Hospice 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident death filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, Hospital or Attending after death Director: 24 hours a the ျှ

Baltimore, Maryland 21215-0036

within To the

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

29b. Signatu

30. Name and

one)

31. Date filed (Month, Day, Year) OCT 1 6

address of person who

32. Registrar's Signature

ompleted cause of death (Item 23a) (Type, Print)

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

License number

estminster

29d. Date signed (Month, Day, Year)

Flavio Kruter,

State Registrar 31. Date filed (Month, Day, 1)

Year)

1 8 2007

egistrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

State

Registra

30. Name and address of person who completed cause of death (Item 23a)

6 200

Assistant Medical Examiner

32. Registrar's Signature

Melissa Brassell, MD

31. Date filed (Month Car, Year)

111 Penn Street, Baltimore, MD 21201

07-08233

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 35000

nes Easter			State of Maryland / Department of Health and Men or State	ntai riygicin			
	_	Reg	intro	2. Date	Reg. No. of Death		3. Time of Death
hysiciب		1. [	Decedent's Name (First, Middle, Last)	Mont	ber 22, 200	Year 07	2150 hrs
Exam	ine		James Wiley Easter, 111.			. County of Death	1
		4a.	Facility Name (if not institution, give street and number)  Harford Memorial Hospital  4b. City, Town, or Location  Havre De Grace		۱	Harford	
			Figure 1 Voca Lift In	nder 24Hrs. 8. Dat	te of Birth (MM.	/DD/YYYY) g. Bir	thplace (State or Foreign
Funeral		5.	Social Security Number 6. Sex 7. Age (III yrs. last bill blody)  Months Days Hou	uco Min		Co	ndiana
Director			220-50-4512   1XM 2 F   60 Yrs.	Au	g. 21,	1947 1	nacana
	1	Us	ual Residence of Decedent				10d. Inside City Limits
any	1	10	a. State 10b. County 10c. City, Town or Location				1 Yes 2 XINo
× ×	۽ ا	11	aryland Harford Aberdeen		140-09	tizen of What Cou	intry?
Maryland 28a-f show d at once,	{	10	e. Street and Number		10g. Ch	(IZEIT OF WITHING CO.	[
death with the Maryland or items 23a or 28a-f sho	Director	<u> </u>	1031 Old Philadelphia Road 21001		u.s	.A	
ith th	-	11	Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Co.	Origin? (Specify Ye	es or No-	14. Race - Ame White, etc.	rican Indian, Black,
ath w tems	long of the	1	Never Married 2 X Married Armed Forces?		610.)		
er de			Nidowed 4 Divorced If Yes, Give Year 1 Yes 2 X No spec				rite
s after	1 3	<u>-</u> [≊	Tor Dates: 16a Decedent's Usual Occupation (G	ive kind of work dor	ne 16b.	Kind of Busines:	s/Industry
hour fraft		<u>₽</u> ⊢	Elementers/Secondary (0-12) College (1-4 or 5+)				
36 in 72 han '			19 Solk Employed In	uck Drive		Trucking	9
5-0036 led within 72 hours after Hygiene. 1 other than "natural",		najaidwo 1	7. Father's Name (First, Middle, Last)	ther's Name (First,	Middle, Maide	n Surname)	
215-0036 be filed within 7 ntal Hygiene. rked other than	2 2	8 6		ildred Th	none (	Zook)	
21215-003( July be filed within I Mental Hygiene. I marked other the Methic count the Methic	<u></u>	n 1	Go. Leformant's Name(Relationship (Type, Print )  19b. Mailing Address (Street and	Number or Rural R	toute Number,	City or Town, Sta	
Shoul shoul		-   '	Susar J. Easter (Wife) 1031 Old Philade	elphia Ro	oad, Ab	erdeen,	MD 21001
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Interference of marked other than "natural", or items 23a or 28a-f she and the Maryland Framiner must be notified at once		2	0a. Method of Disposition 20b. Place of Disposition (Name of cemetery	y, Date	200	c. Location - City	or Town, State
S   a	ler l		0a. Method of Disposition  Cremation 3 Removal from State Crematory or other place)  Harford Mem. Gardens	10/26/2	2007 A	berdeen	Haryland
Page nent	5		4 Donation 5 Other Specify:				
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If tiem 27 is ma	Ē	12	1. Signature of Funeral Service Licensee 122. Name and Address of Zellman Mitchell Snuth Funeral Home 123 S. Uashington St. Havre de Grace. MD 21078  123 S. Uashington St. Havre de Grace. MD 21078				
മ ೩೭೨:	=	$\Delta$	33. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such	as cardiac or respi	iratory arrest,	shock, or heart	Approximate Interval
ysicia	ın	Ż.	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying soon failure. List only one cause on each line.				Between Onset and Death
Medic			mmediate Cause (Final disease a. Complications of Anastomotic Leak				
Examine	er		or condition resulting in death)  Due to (or as a consequence of):				
		- 1	Sequentially list conditions, b.				
		힐	if any, leading to immediate Due to (or as a consequence of):  cause. Enter Underlying Cause				
	4	Ē	(Disease or injury that initiated Due to (or as a consequence of):				
- Pr	nsit	Examiner	events resulting in death) Last				
0, e be executed ysician and	- tra	ᇹ	X UNPENDED X AM#NDED3a, PII, 27, 28a-f, perME, g873, 11	/20/07 TT			
O, e be e ysicia	burial	edical		<u> </u>		23d. Date of del	
76 ficate g phy	for use as the f		3b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3	Ectopic pregnancy		Month	Day Year
68 certi	ise as	흥	past 12 months?  4 Pregnant at time of death 5 Other (Specify)				
Box 6876 e death certificate the attending phy	for 1	Physician/M	1 Yes 2 No 9 Unknown g Unknown			- andribut	e to the cause of death?
D. E. the chapth	ched	됩	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I.			Probably 4 Unknown
P.C s that	be detach	Completed by	Retained foreign body		1 Yes		
S, quire en si	ald b	te	100011100 10001		24a. Was an autopsy	24b. We	re autopsy findings available r to completion of cause of
Orc IW re as be	2 should	읣			performe	ed? dea	
he la	age	E			1 <b>Y</b> Yes 2	INO I	163 2
Z iii iii	tor, p		25. Was case referred to medical	Death (Check only		esidence 6	Other:
Division of Vital Records, P.O. Italian or Attending Physician: The law requires that the star effect that the star effect of the Affect this certificate has been signed by	direc	o Be	1 Yes 2 No	Nursing Ho		50.00	
of of B	neral	<b>⊢</b>	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury a	at Work?	opao dur	ing evolor	Retained surgicatory laparotom
	ie fur	io	Natural 5 Pending Oct 12,2007 unk	2 X No SPO With	th color	reanastor	OSIS
SiSi Atte	by th	ica	28e. Place of Injury - At home, farm, street, factory, office build	ding, etc. 28f	<ul> <li>Location (Str or Town, Sta</li> </ul>	eet and Number te) Ha	or Rural Route Number, City Vre De Grace, N
	ed in	ij	3 Suicide 6 Could not be determined (Specify) Hospital	Ha	arford M	emorial Ho	spital,
Spita	y fill	ညီ	4 Homicide	and place, and due	e to the cause(	(s) and manner a	s stated.
Division of Vital Records, P.O. Box 68760  To the Hospital or Attenting Physician: The law requires that the death certificate I within 24 hours after death.	completely filled in by the funeral director, page	Medical Certification:	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de	eath occurred at the	e time, date ar	nd place, and due	e to the cause(s)
To within	con	pa	and manner stated.  29b. Signature and title of certifier  29c. License n			29d. Date signed	(Month, Day, Year)
		2	29b. Signature and title to certifier  O.C.M.	.E.	Ì	October 23,	2007
			Hamate Mouthall, Mil				
8			30. Name and address of person who completed cause of death (Item 23a)  Romela E Southall MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201				
~			Famela L. Oddilali, W.D. , testetan treat	Dalamore, MD			
		tate					
Re		trai	OCT 3 1 2007 Decision At April 1		0	CME	